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JUST ARRIVED, this child has a life expectancy of 66.3 years. His most dangerous days, however, lie just ahead, for the death rate in the first month of life is greater than in any other period except in old age. Factors in the death or damaging of children before, during, or just after birth are discussed, along with possibilities for prevention, in the lead article in this issue.

On publication of his book "Perinatal Losses in Modern Obstetrics" 2 years ago, Robert E. L. Nesbitt, Jr., was designated by the U.S. Junior Chamber of Commerce as one of the 10 outstanding young men in America. Before going to Albany in 1956, he was chief of obstetrics in the pathology laboratory of Johns Hopkins Hospital and acting head of the hospital's department of obstetrics. He has reported extensively in medical journals on his researches on pathologies in pregnancy and the causes of fetal and infant deaths.

In the 13 years since she joined the staff of the Boys Industrial School in Topeka—with the promise to stay a year—Leita P. Craig has been active in the development of the treatment program there. Previously she was on the staff of the Kansas Receiving Home for Children in Atchison. She has also been an elementary school teacher and a principal in the Atchison public school system.

Pediatrics was Geoffrey Martin's chosen field until he went to Kansas in 1947 to work in a child health demonstration unit out of "curiosity" about public health. He stayed to become assistant director and then director of the State division of maternal and child health, and then, a year ago, State health officer. He was previously assistant in pediatrics at the Johns Hopkins' medical school.

Trained professionally in both education and social work, Sara-Alyce P. Wright has been in YWCA work for the past 12 years—for 4 of them in Youngstown, Ohio, where she was program director of the local "Y," and for the past 8 at national headquarters, where she carries special responsibility for the development of program for young people between the ages of 12 and 18. She is chairman of the youth services committee of the National Social Welfare Assembly.

Before coming to the Children's Bureau in 1950, Catherine E. Harris was for 3 years in the Office of Education, 2 of them spent in research and statistics. During the war she worked in the Colorado River center of the War Relocation Authority in various capacities—employment registration, public assistance, high school teaching. She has also taught in high schools in and near Chicago.

While directing the delinquency project for the National Education Association, William C. Kvaraceus is on leave from Boston University, where he is professor of education. Creator of the KD proneness scale and checklist for attempting to identify delinquency susceptibility in children, he is also engaged in a 3-year research project on prediction of juvenile delinquency, sponsored by the U.S. Office of Education.

◀ *the authors*

An obstetrician reviews the extent, causes, and ways of preventing . . .

PERINATAL CASUALTIES

ROBERT E. L. NESBITT, JR., M.D.

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THE PERIOD of human existence between the end of the 19th week of gestation and the end of the first month of postnatal life presents a greater hazard to the individual than any other period from then until old age. The magnitude of the problem is illustrated by the fact that deaths of viable fetuses and newborn infants make up about 10 percent of all deaths occurring in the United States today.

As great as these losses are, they represent only a part of the total problem of casualties associated with birth. It is now abundantly evident that the factors responsible for dead fetuses and infants and those responsible for damaged infants are very much the same. Thus, there is an aftermath or "continuum" of the birth process that is of grave concern. Infants with sublethal injuries may develop a number of potential and real neurological sequelae, including epilepsy, mental deficiency, cerebral palsy, and even abnormal behavioral patterns appearing in later childhood.

Any definition of casualties connected with birth process must be sufficiently broad to encompass a wide spectrum of events, including fetal death in utero at all stages of gestation, death of liveborn infants during the first month of life, malformation, and permanent disability because of some type of injury before, during, or immediately following the birth process. The period of time covering the total birth process is referred to as the perinatal period, and mortality and morbidity incurred by fetuses and infants during this span of human existence are designated as "perinatal casualties."

The concept of a perinatal period is useful in many ways, but because it has been only recently widely employed there has been confusion about the time period involved. The definition proposed by the American Medical Association—from the 20th week of gestation through the 28th day of life—is receiving wide acceptance.

In a total appraisal of reproductive wastage, however, it is necessary to consider the loss of products of conception at any stage after the union of the two pronuclei in the fertilized ovum, as well as the antecedent genetic and environmental background of the mother. Patients who have experienced reproductive failure frequently have a similar etiologic background with patients showing infertility, pathologic manifestations of menstruation, and other gynecological disorders.

The recurring nature of these interrelated problems explains the fact that about one-fourth of all patients experiencing reproductive losses account for nearly two-thirds of all the losses.[1] The incidence of previous gynecological symptoms in these women is high, indicating that preconceptional care is an integral part of obstetric care. Such care or its lack has a direct influence upon the incidence of perinatal casualties, both immediate and remote.

A condensation of three papers presented at the Institute on Perinatal Casualties, sponsored by the schools of public health of the University of Michigan and the University of Minnesota, Minneapolis, December 8–13, 1958. The full papers, containing considerably more medical material, appear in the proceedings, just published by the Center for Continuation Study of the University of Minnesota. Single copies from the Center on request.

Clearly then, any thorough appraisal of the problem of perinatal casualties requires a multidisciplinary approach. Attacking the problem of fetal and maternal welfare must be part of the general health program and cannot be relegated to any single group of medical scientists. The problem is primarily one of community health. It involves medical scientists, clinicians, nurses, and public or community health workers; and through its relation to socio-economic status, it becomes the concern of demographers, nutritionists, sociologists, economists, political scientists, and, of course, the general public.

Extent of Problem

Perinatal casualties do not lend themselves to precise summation, but they are believed to exceed 900,000 annually in the United States.[2] This estimate includes disability immediately or subsequently apparent as an aftermath of the birth process as well as the mortality in the perinatal period.

Since reliable figures on morbidity and remote sequelae do not exist, advances in coping with the problem must be judged from mortality statistics, available from the Public Health Service's National Office of Vital Statistics. Between 1933, the first year for which such statistics are available for the Nation as a whole, and 1956, the infant mortality rate (deaths under 1 year of age) dropped 55 percent. All age groups shared in the reduction but in differing degrees, the greatest reduction occurring in the age group 6 to 11 months and the least in the group under 1 day, at 1 day, or 2 days old.

Despite reductions, deaths in the perinatal period still represent an enormous loss of human life. Today deaths of viable fetuses and newborn infants come to about 165,000 each year in the United States. An even larger number of deaths, approximately 425,000 annually, occur as spontaneous abortions in the previable stages of pregnancy.[3] There are indications too that the sharp decline in perinatal losses which took place during the years 1935 to 1945, an era of rapid medical and social progress, has gradually leveled off during the present decade.

Although premature birth occurs in less than 10 percent of all pregnancies terminated after the period of fetal viability, prematurity is associated with more than one-half of all perinatal deaths. In New York State at the present time about 60 percent of the fetal deaths of more than 20 weeks' gestation and about 75 percent of the 6-day postnatal deaths occur in fetuses or infants weighing 2,500 grams or less at delivery. In upstate New York, during the period 1945–54, the neonatal mortality rate adjusted for birth weight declined by more than 30 percent, but the greatest decline occurred among the larger infants. No decline occurred among infants weighing less than 1,000 grams.[4]

Role of Vital Records

Many public health agencies are attacking the problem of perinatal loss, through the continuing analysis of the data available from fetal, maternal, and infant death certificates and livebirth certificates. A major objective in such analyses is to show where knowledge is lacking in order to stimulate further research and study.[5] Although there are important sources of data in hospital material, or from obstetrical-statistical cooperatives, a multidisciplinary attack on perinatal losses requires the exertion of every effort to correct deficiencies in the procurement and tabulation of data from vital records.

Indications are that the quality of death certificate data for perinatal deaths could be improved by a more intensive study of available clinical records and by use of data on pathological conditions, especially in assigning causes of death during the neonatal period. A recent study found that in 40 percent of the fetal and infant death certificates submitted to the Baltimore City Health Department by a hospital, the cause of death given failed to agree with the cause given on a special certificate based upon careful study of the findings on clinical and pathological conditions and the comments of a committee of medical experts.[6]

A comparison of the percentage distributions of the causes given on the special and other certificates showed the following:

1. Fetal deaths were ascribed to causes and conditions in the mother about twice as often on the special certificates as on the others.

2. The frequency of causes determined in fetus, placenta, and cord was about the same on the different sets of certificates.

3. Fetal deaths were ascribed to unknown or ill-defined causes less frequently on the special certificates than on the others.

For neonatal deaths agreement between the special and original certificates was only 46 percent, excluding the rubric, hyaline-like membrane disease, which was not used when the original certificates were coded. Infection of the newborn was also found more frequently on the special certificates than on the others.

To evaluate properly the frequency of specific causes of perinatal death or to compare perinatal mortality rates, one must know the incidence of such multiple factors as race, parity, age, economic class, and the proportion of maternal complications in the respective population samples. These factors are highly interrelated and are associated significantly with the infant's birth weight as well as the general reproductive outcome.

The Etiology

The determination of the causes of perinatal death is subject to peculiar difficulties. All methods of classification thus far devised have failed in one way or another. Present knowledge concerning maternal, fetal, and placental factors is not sufficient in all instances to identify and separate the specific causes. Almost one-third of all perinatal deaths are unexplainable through current study technics.

The underlying cause of perinatal death often does not reside within the infant's body and so cannot be determined by autopsy alone. It may reside in the mother or in the placenta.

In recording each death every effort should be made to determine the underlying cause. If the cause is indeterminable, it is preferable to ascribe the death to unknown causes than to the ultimate clinical or pathologic condition. Certain fetuses and infants with insignificant pathologic findings may have been insulted by anoxia or trauma over a short period of time without being left with detectable signs. It is especially difficult to classify such cases when the clinical records are deficient. Any measure of success in determining the primary pathologic cause of death depends upon the correlation of a detailed pathologic examination with a reliable obstetric and pediatric history.

The initial stages of standardization of technics, clarification of definitions, and classifications of death are indispensable to the task of reducing perinatal losses. Granting that there are serious limitations in our current classifications, they have nevertheless exposed the problems that need concentrated study.

Classifying Causes

Several large independent studies of perinatal mortality have pointed out the same major causes of death and have estimated their incidence in relatively the same order of importance.[7,8,9,10]

The opinions concerning the relative frequency of various specific causes of perinatal mortality expressed in the following paragraphs are derived in large measure from the studies of Nesbitt and Anderson,[7] carried out on clinical and pathological material from the Johns Hopkins Hospital.

Anoxia. Anoxia is responsible for more deaths in the perinatal period than any other etiologic factor. It may be considered the primary cause of death when interference in the supply of oxygen from mother to fetus has produced structural changes in the fetus or infant visible at autopsy. It may be derived from a variety of factors—the placenta, cord, maternal diseases, difficult labor, and other complications.

One-third of all perinatal deaths in obstetric departments that care for a high percentage of indigent patients are attributable to anoxia. Moreover, anoxia is the principal common denominator between dead and handicapped infants, only a matter of degree and duration of insult determining whether the infant is killed or merely damaged.

Birth Injury. Deaths from birth injury include deaths of fetuses and infants who die as a direct result of injury during the mother's labor or delivery, usually intracranial injury, and of those who die from intracranial lesions initiated by anoxia. Such injury is the cause of slightly less than 10 percent of the total number of perinatal deaths. In about three-fourths of such cases there has been some type of significant maternal complication. Intracranial lesions and hemorrhage attributable to anoxic injury are much more common in premature than in mature infants.

Malformation. Malformations incompatible with life are responsible for about 9 percent of all perinatal deaths. The incidence of malformations as a cause of death is much more common in premature than in term infants. There is a close etiologic relationship between malformations and a variety of reproductive problems, including fetal death, both early and late, certain neonatal complications, premature birth, and habitual abortion. Available evidence suggests that a faulty maternal organism is the common factor that creates an unfavorable intrauterine environment for the fetus. Only a small minority of these abnormal obstetric events seem to be genetically determined.

Abnormal Pulmonary Ventilation. The problem of respiratory insufficiency in liveborn infants in the first several days after birth includes immature lung tissue and hyaline-like membrane disease. Hyaline-like membranes in association with pulmonary

atelectasis (imperfect expansion of the lungs) are found in a large group of cases with abnormal pulmonary ventilation, which ranks high as a causative factor in neonatal death, particularly among premature infants. Nearly one-fourth of all deaths of premature infants during the neonatal period are attributable to pulmonary pathology.

A number of obstetric factors are associated with the incidence of hyaline-like membranes in the newborn. These factors are premature birth, maternal diabetes, and delivery by Cesarean section. The incidence is also increased in association with breech delivery, multiple delivery, and maternal toxemia, but it seems likely that a high incidence of premature birth in these conditions may account for this finding:

Infection. Considerable attention must be directed to all clinical and pathologic findings in ascribing infection as a sole cause of death, since infection, particularly pneumonitis, is a terminal finding in many infants dying of other conditions. Deaths that are properly classified as caused by infection should have infection reported as the underlying cause, not merely as an ultimate complication. Infection as a primary cause of death assumes major importance as a cause of death in the postneonatal period, but it accounts for only about 5 percent of the total perinatal deaths.

Pneumonia occurring within the first few days of life as a result of intrauterine infection is a rather frequent finding in term infants. Long labors, prolonged rupture of membranes, particularly when the fetus is of term size, and intrapartum fevers are often associated with contamination of the amniotic fluid with bacteria.

Septicemia also occurs in infants on rare occasions. Although still a relatively minor cause of perinatal mortality, outbreaks of infections due to penicillin-resistant staphylococci are becoming more frequent.

Erythroblastosis. Hemolytic disease of the fetus and newborn infant, caused by Rh factor incompatibility in the parents, is a relatively minor specific cause of perinatal death because of its comparatively low incidence. Moreover, there are striking differences in the incidence among the races. It is responsible for only one perinatal death in about 1,500 births in obstetric clinics caring for large numbers of Negro patients. In hospitals where the clinic population is predominantly white it occurs approximately three times as often or about 1.8 per 1,000 births.

Other Conditions. Apart from the major categories of perinatal death, there are occasional conditions which counted together are responsible for less than 1 percent of all perinatal deaths. They include such unrelated conditions as advanced ectopic gestations, fetal hydrops (accumulation of fluid) of unknown cause, congenital tumors, marked increase in intracranial pressure without evidence of intracranial lesions at autopsy, placental infarction, and complications of the umbilical cord.

No Abnormal State. After classifying perinatal deaths in accordance with these major categories, there remains a substantial number of deaths, perhaps as many as 30 percent of all, without demonstrable lethal factors to explain them. The great majority of such cases are fetal deaths in utero, usually occurring before labor. About one-fourth of these fetuses have been delivered of mothers having significant maternal disease, usually toxemia or diabetes. Improved technics for the study of tissue antibodies (fluorescent microscopy) and of viral infections may decrease the number of unexplainable perinatal deaths.

Prematurity and Abortion

Prematurity should not be listed as a specific cause of perinatal death, although certain of the aforementioned causes of death are more commonly seen in premature infants. The major factors in perinatal death of premature fetuses and infants, in descending order of importance, are placental complications, abnormal pulmonary ventilation, toxemia, birth injury, malformation, and infection. However, the impact of the factor of prematurity upon neonatal mortality is evident in all of the specific causes of death. When birth weight is taken into account the death risk of liveborn infants born to mothers with placenta previa is 2½ times that of liveborn infants born to mothers with no obstetric complications, whereas if birth weight is not taken into account the risk is 13 times as great. Similar observations have been made in regard to abruptio placenta.

Although much is known of the physiology and pathology of early abortion, an understanding of the etiologic factors involved has lagged far behind advances in other areas of obstetrics. A multiplicity of mechanical, clinical, physiological, psychological, and endocrinological factors have been implicated as causes of repeated abortion. These factors may be considered under the rather broad heading, "faulty maternal environment." It has become increasingly apparent that faulty environment for the developing ovum and fetus may be a factor common to a broad spectrum of specific types of fetal wast-

age, including early and late fetal death, premature birth, and malformation. Thus, it is important to subject patients who have demonstrated any one of these specific types of reproductive failure to careful study.

Great voids obviously exist in the understanding of many of the basic principles involved in perinatal loss. Autopsies must continue to be energetically sought, and emphasis must be placed upon the acquisition of better clinical materials.

Morbidity

The factors responsible for dead infants and the factors responsible for live but damaged infants are very much the same. Most studies show that premature birth, birth injury, third-trimester bleeding, placental complications, advanced maternal age, and intrapartum infection are frequent antecedents to delivery of infants with permanent neurological damage.

Eastman and DeLeon [11] report that 78 of 96 cerebral palsied infants subjected to careful study were born to mothers who had significant maternal complications. This study tends to add additional support to the growing opinion that anoxia incurred perinatally is a major cause of cerebral palsy and other neurological sequelae. Current and prospective studies should offer a clue to the precise etiologic factors and to measures for prevention.

Factors in Prevention

The prevention of perinatal casualties is a joint responsibility of several health disciplines, including obstetrics, pediatrics, anesthesiology, nursing, hospital administration, and public health. The adoption of a multidisciplinary approach to the problem of perinatal casualties represents the *initial step* in its solution.

The *second major factor* in prevention is the wider application of what is now known about patient care. It is not always necessary to know the finite causes of disease or death in order to take effective measures to control them. Maternal toxemia is a classic example. It has been stated that meticulous prenatal care is likely to eliminate toxemia as a maternal complication before its precise etiology is understood.

Statewide statistics do not make clear the fact that some counties within the State may have rates far in excess of the mean perinatal mortality rate for the State. Such differences call for a look at differences in services.

The *third major factor* in prevention is the elevation of living standards among the underprivileged classes. Low standards of obstetric care, low standards of living, and ignorance go hand in hand. Measures directed toward providing adequate facilities, personnel, and lay education have a positive influence on perinatal losses. Better nutrition and housing, good sanitation and adequate financial resources to ensure a decent livelihood, equal opportunity for education, and expanded social rehabilitation are necessary tools in the reduction of premature birth and to greater fetal and neonatal salvage.

Preconceptional Care

There is reason to believe that correction of all demonstrable medical, endocrinologic, and other kinds of defects, including emotional problems, prior to and during pregnancy, will enhance the probability of fetal salvage. The outlook for patients who have a recurring factor responsible for a high rate of reproductive waste, particularly habitual abortion, may be considerably improved by appropriate therapy prior to conception. Thus, a *fourth factor* in the prevention of perinatal casualties is preconceptional care.

Specific and supportive therapy in chronic illness, attention to the patient's diet, hygiene, habits, and psychological status, and the correction of endocrinologic and anatomic defects are important. Public health agencies should support this broadened concept of obstetric care by developing community "preconceptional" clinics set up to evaluate women who have demonstrated reproductive problems.

Professional and lay education is a *fifth major factor* in prevention of perinatal losses. Public health agencies can assist the obstetrician immeasurably by offering courses of instruction, medical films, teaching aids, and a continuous educational program for expectant mothers. Medical centers can join with other health agencies in providing professional programs of postgraduate education for practicing physicians, intramurally or extramurally. A technic which has proved valuable is the perinatal conference, in which fetal and neonatal deaths are discussed by obstetricians, pediatricians, pathologists, anesthesiologists, and other interested physicians.

A continuing analysis of perinatal mortality and morbidity at the local level is imperative. Since the problems associated with reproductive wastage vary greatly from one community to another, effective preventive health programs in one area may not be directly applicable in another. Thus, the establish-

ment of perinatal mortality conferences on a community-wide basis is desirable.

Obstetric Management

A *sixth major factor* in prevention is the evolution of a clinical attitude in obstetrics which emphasizes conservative technics of management as a means of avoiding anoxia and trauma.

Fortunately, in the majority of cases, the obstetrician can anticipate the underlying problem of intrauterine anoxia and so prevent or minimize it by proper obstetric management. When the fetus is subjected to anoxia from unavoidable maternal complications, an avoidance of multiple insults to the fetal respiratory center should be the primary objective during labor and delivery.

Space does not permit a detailed account of the management of specific obstetric complications. Suffice to say that dissemination of current knowledge concerning conduct of premature labor, judicious use of analgesic and anesthetic drugs, antepartal prophylaxis against toxemia, prompt recognition and treatment of medical illnesses, attention to and supplementing of diet, proper attention to iso-immunization, induced labor prior to term in selected cases, surrounding patients with safeguards of blood replacement and appropriate chemotherapy, proper evaluation of the pelvis, judicious use of uterine stimulation, and expert resuscitation and care of the newborn infant will do much to assure optimal perinatal salvage.

With few exceptions, the longer the fetus can remain in the uterus the better are its chances of extrauterine survival. Certain medical advances in the management of specific medical illnesses, such as heart disease, diabetes, infectious diseases, and tuberculosis, have made it possible for some patients under therapy to proceed further in pregnancy than formerly. However, it is likely that the major part of the problem of premature birth—unattended by maternal complication in about 60 percent of the cases—is specific in nature and lies in the basic mechanisms of the smooth muscle cell and its metabolism as well as its neurologic and endocrinologic control.

The obstetrician must acquaint those entrusted with newborn care with any antecedent obstetric factors which may conceivably lead to intracranial injury through anoxia or trauma. The ultimate prognosis for the infant during the ensuing days, months, and years may in large measure depend upon the effectiveness of management during the critical minutes following birth.

Public health agencies should assist private organizations in providing clinic facilities for the prolonged followup of infants who responded poorly at birth or who were born under circumstances likely to terminate in remote sequelae.

More Knowledge

The *seventh factor* in planning for prevention of perinatal casualties is the continued acquisition of knowledge. Fully one-third of all deaths in the perinatal period are unexplainable through our current technics of study. A very large segment of the combined fetal and maternal mortality in the United States is due to functional disorders of the uterine muscular structure. Yet, when we look into these problems of uterine dysfunction, we find that we are ignorant of much of the basic pathophysiology involved. Even a basic understanding of maternal-fetal-oxygen relationships, and the precise effects upon the fetus, both immediate and remote, are fragmentary.

Broad areas of research must be encouraged in regard to levels of human reproduction and comparative physiology. Application of the knowledge gained to the betterment of perinatal welfare will inevitably follow. But the problem must be solved ultimately through the coordinated activities of multidisciplinary groups.

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REACHING DELINQUENTS THROUGH COTTAGE COMMITTEES

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THE OFFICES of the clinical personnel at the Boys Industrial School in Topeka, Kans., are strangely deserted between the hours of 9 and 11 a.m., 5 days a week. This is the time set aside for the cottage committee meetings in the various cottages. Every day the social workers, psychologists, and psychiatrists leave their offices to go to their assigned cottages for the meetings. Similarly, the chaplain, the educational and vocational coordinators, the directors of recreation and cottage life, the clinical director, and the superintendent attend these meetings, going from cottage to cottage according to a plan or a request for consultation. A teacher having difficulty with a certain boy may attend the meeting at his cottage to work on the problem with the committee, and occasionally some of the county social workers come in to help make plans for a boy to return to the community.

The Boys Industrial School is a State institution for boys who come into conflict with the law while under the age of 16. The present population of 170 boys ranging in age from 10 to 17 live in four dormitory-type cottages accommodating 30 to 60 and in two small cottages accommodating 9 and 15. There is also an orientation cottage where new boys live during a 3-week diagnostic period.

The cottage committee system was conceived in desperation after a number of years of trying to establish an effective treatment program on the part of professional staff. It is our effort to solve the perplexing question of how to get the clinical understanding to the people who live and work with the boys. It is also our attempt to answer the equally perplexing problem of how these people can share with their colleagues in offices the understanding they gain from their close association with the boys.

The interdisciplinary cottage committees meet for the sole purpose of achieving better understanding of the boys in their care and helping each to benefit from the treatment program planned especially for him. Upon entering BIS, a boy is told that his cottage committee represents his "home base"—the people who will work most closely with him and who will know the most about him, to whom he may take his problems and his plans, his joys and disappointments, and who together will carefully and systematically evaluate his progress, discuss his goals, and eventually make plans for him to leave the school.

Committee Members

The basic cottage committee consists of the senior child-care worker (classified under State civil service as a "cottage parent"), the social worker, and either a psychologist or psychiatrist as the team coordinator. Each person has a role to play in the total work to be done.

The role of the child-care worker is to represent management. He is concerned not only about individual boys but with providing the total group of boys in his care with good child care and an adequate group-living experience. He must strike a delicate balance in meeting the needs of a particular boy without allowing this to interfere with the total welfare of the group. He must provide a well-structured, clearly defined, balanced, educative, and supportive environment for the boys. He invariably becomes

an important identification figure for the boys in his care.

The social worker is the liaison between the boy, his home, and the community. He is the authority in the committee when questions concerning family relationships, community pressures, the advisability of a pass or parole are discussed. He carries responsibility for clearing with the appropriate authorities all legal requirements and rights involved in passes, paroles, and related matters. While he is working with the cottage committee to help get the boy ready to return to his home he is also working with the family and the community to ready them to receive the boy.

The team coordinator has responsibility for leading the others in interpreting each boy's treatment needs and goals. He points out the psychological dynamics in the boy's behavior. He puts together the information given by the child-care worker, the social worker, the academic and vocational teachers, the therapist, the chaplain, the recreation leader, and the athletic coach to make a meaningful picture of what is going on within the boy. If it seems impossible to understand the boy as a total functioning being, the coordinator has responsibility for searching for the missing key. He also carrier responsibility for the boys' clinical treatment as well as responsibility for the effectiveness of the committee's work as a team.

No one discipline is more or less important than the others in the committee's total functioning, for they are interdependent. Each member, trained in his own particular discipline, understands best a particular facet of the boy and strives with the others to understand him as a total functioning being.

Since the cottage committee represented an entirely different way of working from what the staff was used to, we had much to learn and many problems to solve as we went along. From the beginning the coordinators have met in a weekly seminar with the clinical director to discuss problems. The seminar has been enlarged from time to time, to include all the basic committee members as the need arose. The meetings have been helpful to an understanding of the process, although sometimes painful.

For example, we did not anticipate the intensity of the relationship which would develop between the boys and the cottage committee and so were unprepared to deal with our feelings. Specifically this means that the boys tended to react to us both as a group and individually as they had reacted to the important figures in their lives. As they directed these old feelings toward us we were caught in the trap of reacting as if the feelings were meant for us personally. This was even more pronounced with the boys in psychotherapy and it soon became apparent that the therapist and the cottage committee must work closely together.

Team Relationship

To build an effective team relationship is no easy task. The barometer which tells if this relationship is as it should be is complicated, sensitive, and accurate. It is the boys themselves. We have learned over and over again that when a specific cottage of boys is restless—quarreling, fighting, strong-arming, running away—to look first at ourselves and then at our committee relationships. As soon as we begin to untangle our feelings, get the lines of communications straight, and perhaps redelineate our roles, the cottage settles down. In reacting to our uncertainty and instability as a committee, the boys act out their conflicts just as they have reacted to the instabilities, conflicts, and weakness in their own families.

Thus it is not only necessary to redelineate our roles for ourselves, but it is important that the boys understand these roles. A common denominator of juvenile delinquents is an uncanny facility for figuring out social situations, even though they cannot understand them. They learn this in order to manipulate for their own gains. To prevent them from trying to manipulate the cottage committee it is essential they be given an understanding of the roles within it.

There must be a basic trust and respect between the committee members, both as persons and as responsible representatives of their disciplines if a working relationship is to be developed. If the child-care worker views the committee members as spies he will not be effective as a team member. On the other hand, the coordinator who sees his role as "boss" or the "authority," or the social worker who delves into management, is also ineffective as a team member. One cannot force a working relationship; it is developed painstakingly, piece by piece as the individuals work together on a common goal.

In addition to trust in each other among the cottage committee members there must be mutual trust between cottage committee members and the boys with whom they are working. This is extremely difficult to achieve, as another common denominator in delinquents is their reluctance to trust anyone, least of all authority figures—a projection onto all adults of their hostile feelings towards the signifi-

cant adults in their lives. Sometimes we are not able to reach a boy because we cannot gain his confidence.

The basic committee is enlarged from time to time to deal with specific problems, especially with other members of the child-care staff—housemother and day and night supervisors—who can contribute significantly to an understanding of the individual boys. For example, the night supervisor often has most important information concerning the boys' sleeping habits—whether they have nightmares, or walk or talk in their sleep. Similarly the housemothers often have intimate knowledge of what is troubling a boy, since many boys, held back from going to the male supervisors because of their conflicts with men, go to the housemothers with their problems. Sometimes the key which unlocks the understanding of a particular boy is held by the coach, the auto mechanics teacher, the librarian, the school janitor, or some other person with whom the boy has been able to develop a relationship.

The institution's division heads attend the committee meetings on a rotating basis or by appointment when they feel the need. Or a boy scheduled for what he feels will be a difficult cottage meeting, may ask his psychotherapist, the chaplain, or someone with whom he has a supportive relationship, to attend.

Ways of Working

The cottage committee system was inaugurated in September 1954, primarily to give support to the child-care workers, of whom the impossible was being expected. They were supposed to get enough from the diagnostic clinical staff conferences to be able to treat each boy in their care according to his needs and the clinical recommendations. Consequently, they generally felt defensive and were apt to view other staff members who came into the cottages as spies. The problems dealt with were the chronic ones, which were numerous.

At first the committees worked mainly on crises. It took some time for us to realize that this was a way of avoiding a realistic look at the problems of working together. As we understood this better, we were able to establish a substantial way of working together as we dealt with crises. Then, surprisingly enough, the crises began to diminish, and we could begin to think about a planned method of working.

By now each cottage committee has developed its own way of working, which depends upon the age group of the boys concerned as well as upon the

A boy at the Kansas Boys Industrial School takes a problem individually to a meeting of his cottage committee, whose members (from left to right) are: senior child care worker, social worker, cottage mother, clinical psychologist.

experience and predilection of the individual staff members. However, basic similarities exist in all procedures. For example, each cottage has one meeting a week attended by all cottage personnel. This serves as a clearinghouse for problems of working together to provide a consistent, therapeutic cottage milieu.

At this weekly meeting problems of management are discussed, the boys are reviewed from the standpoint of changes, behavior, or problems presented, and recommendations are made as to passes, paroles, or changes in treatment plans. Clinical information in regard to new boys is presented and goals for them agreed upon.

The committee also meets with all the boys in the cottage together at least once a month and in some cottages every week. These assemblies have proved effective for working out inconsistencies in management, as well as cutting down on the possibilities for manipulations or playing one supervisor against another. Occasionally they are used for special events and thus are important as social, educative, and psychologically supportive experiences.

The committee devotes the remaining four meetings of the week to seeing boys individually and in groups.

Work With Individuals

When a boy attends the meeting alone it may be at his own or the committee's request. If a boy has been

acting out his inner turmoil in aggressive behavior or getting bad reports of other kinds, the committee makes an appointment with him in an effort to find out what is troubling him. After the committee understands the message of these actions it is then in a position to help the boy work it out by helping him to recognize the real problem and often by steering him to the proper person—his therapist, social worker, teacher, coach, chaplain as the case may be—for further help. On the other hand, a boy may want help for some difficulty and may ask for a meeting. He may be having a problem in one of his classes, he may wish an adjustment in his program, he may be worried about things at home, he may want to discuss the possibilities of a pass or parole, and for a variety of reasons he may prefer to take his problem to the committee rather than to the individual staff member most closely concerned.

Sometimes a boy simply wants to ask the cottage committee where he stands. This usually happens when he becomes acutely aware of anxiety. He may ask the committee members if they think he is "crazy," announce that he is having a "nervous breakdown," or simply say he doesn't feel right.

While these problems may eventually need to be worked out in therapy if a boy has a therapist, the cottage committee by definition deals with the day-by-day problems as they occur. So many times a "nervous breakdown is a bid to talk about something else. For example, Donald, a partially sighted boy who denied his handicap and refused to try to be anything other than a fully sighted boy, has his "nervous breakdown" to let the committee know how difficult it was for him and that he was ready to accept help in regard to this problem.

Four boys have a group session with their cottage committee, consisting, in this instance, of (from left to right) chaplain, cottage mother, senior child care worker, relief child care worker, and clinical psychologist.

The most unusual cottage meeting I have experienced was the one at which a boy used a requested appointment to tell the committee how badly his father needed help, saying that he wished the father could get the kind of help he was getting at the boy's school. This meeting occurred after long months of individual help in the committee, during which the boy had struggled with his intense resentment and hatred toward his father. The same boy once told the committee during another requested appointment how much the religious activities at the school meant to him and said "Chapel always makes me feel so gay inside."

Work With Groups

An emphasis upon seeing the boys in groups has developed for both practical and psychological reasons. These boys are at an age at which boys naturally gravitate into groups.

The committees have done considerable experimentation with methods for group appointments. In group selection some cottage committees simply divide their roll by four, while other cottage committees divide their boys according to plateaus of adjustment, the top group consisting of those who are almost ready for parole and the bottom group consisting of the most difficult boys. Two main methods of group selection have been tried in the cottage for older boys. The first plan was based on Eissler's classification of psychiatric disorders into alloplastic (the acting out) and autoplastic (the holding in), with two intermediate groups.[1] These four groups attended the committee meetings on a rotating basis, so that each group was seen once a month. New boys were placed in these groups as soon as they had made their initial adjustment.

A chance remark overheard in the gymnasium one day caused the committee of this cottage to take a serious look at its group formation and working plans. One boy told another that his cottage committee worked very hard with them for 2 or 3 months when they were new, then forgot about them for 6 months, then pulled them out and worked hard with them for the rest of the time they were at BIS. This remark pinpointed for the cottage committee the vague feelings of dissatisfaction its members had had in regard to its work with groups. The com-

mittee then began to see all the boys every week. It decided upon a less technical criteria for forming the groups, mainly because its diagnostic tools were not fine enough to differentiate, and secondly because the "holding in" groups were difficult. The committee also found the boys tended to be more comfortable with boys who were new when they were. Therefore, groups were formed as a part of the natural process of intake—as soon as there were 10 new boys they became a group, having a 30-minute group meeting (sometimes more but never less) with their cottage committee each week as long as they remained at the school.

The cottage meetings for groups are reality oriented and not an attempt at group psychotherapy although the boys experience them as therapeutic and supportive. The purpose is to deal in a concrete, matter-of-fact manner with the everyday problems of the boy's life in the cottage. The boys are told not only that the committee needs to know them but that they need to know the committee. They accept this quite well although their ability to use the group, of course, varies with their individual makeup and the group's composition.

The content of discussion with a new group usually follows a pattern. The boys are told what to expect from the cottage committee and what is expected of them; their feelings and fears about living in a cottage with 40 boys are explicitly recognized.

The boys bring their gripes to the meetings, they suggest ideas, they complain about demands made upon them, or themselves make demands of the committee. Over and over they ask, "How will the committee know when we are ready to go home?" They talk of ways of getting along and holding their own. They have an uncanny aptitude for pointing out inconsistencies.

Behind the boys' complaints are two main questions: (1) Are you strong enough to protect us? and (2) Do you really care about us? Eventually the boys are able to express positive as well as negative feelings, usually when they are becoming strong enough to talk about going home. An important topic in the older boys' group is growing up and taking responsibility.

Continuing Evaluation

The multidisciplinary approach of the cottage committee system allows for continuous evaluation of the boy as a total functioning being. It is carried on informally as the daily log is read, as boys are seen, as special reports are read, as privileges and passes are granted. It also proceeds on a formal basis, each boy being evaluated at least every 3 months in the larger cottages and more often in the smaller cottages.

The formal evaluation is based on progress reports from those responsible for various parts of the boy's program, an interview with the boy, and a tying together of progress with the goals of treatment and criteria of change outlined at the first clinical staff conference. At these meetings recommendations are made for passes, parole, discharge, or further treatment.

The way a boy uses his cottage committee is largely up to him. One boy may choose to act out his conflicts with the committee; another may get strength and support from the cottage committee to work out his conflicts elsewhere. Once he has chosen, the committee is willing to go along with him.

For example, Robert, who had a well-balanced program consisting of library, community living, instrumental music, algebra, welding, varsity sports, and group psychotherapy had begun to show marked general improvement, with more control of impulses and more appropriate affect. He began to experience some meaningful relationships with men, but his conflict with women were causing him a great deal of trouble.

He talked bitterly of "female supervisors." He openly showed his anger to the woman psychologist on his cottage committee, conplaining that he could not understand her because she used such big words. He deliberately cut her off, addressing his remarks either to the social worker or the child-care worker.

One day in his group meeting he suddenly looked very surprised and shouted to the psychologist, "I heard what you said!" There followed many meetings in which he kept driving at her, each time seeming to find something. Finally he was able to relate his feeling toward the psychologist to women in general and thus to his hurt and anger because his mother had deserted him. He gained the strength and support for this insight from his therapist, but chose to act out the problem in his cottage committee, using the psychologist as a transference figure.

Don, on the other hand, reversed this procedure. He acted out his conflict over his father with the printing instructor. As the separation process began, the conflict became more pronounced. The therapist and the cottage committee working together helped the printing instructor understand the

problem so that he would keep on working with the boy.

This instance illustrates the interdependence between disciplines. The cottage committee would have been lost without the help of the therapist, and the print shop would have been unable to tolerate the boy's behavior if the instructor had not understood its meaning.

Relation to Therapist

What is the relationship of the cottage committee to the therapist in connection with boys in psychotherapy?

In the cottage for older boys three-fourths of the boys are in group psychotherapy. At first we thought that these groups would not need to be seen by the committee as frequently as others since they would be seeing their therapists weekly. However, it became even more essential for the committee to see them weekly in order to keep its reality structure clearly defined and let the boys experience the cottage committee as protective and supportive. As the psychological pressure rises within the boys and they become concerned with control of impulses which they do not yet understand, they find support through actions of the committee which seem to say: "We understand, we are in charge, we can protect you."

The therapist also finds support in being able to talk with the cottage committee and learn how the boy is getting along in his day-to-day experiences. The cottage supervisors too find support in being able to understand, when a group of boys become disturbed and restless, that this may be related to the therapeutic process and that they are needed more than ever to provide the boys with the reassurance of a protective milieu.

The cottage committee has become the hub around which the treatment services operate. As such, it has pulled them together. Also, it has minimized the most perplexing of all institutional problems—intercommunication. It has become the clearing-house for information of all kinds concerning the boys, not only receiving information but also sending it out with interpretation of its meaning in regard to the boy's progress and treatment goals.

The cottage committee system has been an important factor in stabilizing the school's entire treatment program by making it possible to reach the boys sooner and to take them further in the treatment process, both by providing a stable therapeutic milieu and by paving the way for more individualized treatment.

The cottage committee has become an important instrument for inservice training of all staff and particularly of child-care workers, giving them support and clinical understanding as well as the gratification of being an indispensable part of the team.

As far as the staff is concerned, we no longer are conscious of a chasm between professionally trained and other institutional workers. There is no longer the feeling that some staff members are on the "front lines" while others remain comfortably in their offices. We are a team of dedicated people, of various disciplines, working together for a common goal and getting gratification as we feel ourselves grow personally and professionally. Our focus is on the boy—his needs, his welfare, his potentialities for becoming a firstrate, productive person and citizen. We offer a multidisciplinary approach to the multidetermined problem of delinquency.

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[1] Eissler, K. R.: Some problems of delinquency. *In* Searchlights on delinquency. International Universities Press, New York, 1949.

We need only remember that underneath the outer mask of an adult size and dignity, behind the official position, rank or prestige of the grown-up man or woman, there is always a little boy or a little girl, still living over the hurts, the injustices, the unhappiness of a forgotten childhood.

Lawrence K. Frank

Some suggestions from a public health administrator on . . .

A PUBLIC HEALTH AGENCY'S ROLE IN ADOPTION

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ADOPTION, in the United States, in 1958, is an extraordinarily complicated field. Is it one in which public health workers have a part to play? My own views of the answer are colored by the experience of the Kansas State Board of Health with foster care to children. This experience has been neither extensive nor profound, and most of it has been peripheral to adoption, but it has had some unique features.

The State board of health in Kansas licenses all types of foster care facilities for children and all private child placing agencies under a law passed through the efforts of the maternal and child health division in 1919. This was originally a solo performance, but in 1951 the law was amended to require specific studies and approvals by the child welfare division of the State department of social welfare before any license was issued. The amendment established a community of interest and a working relationship between the two agencies that is rare in this country. The program involves at present nearly a thousand applications for license yearly, of which something over a hundred are for homes in which children have been placed for adoption by a private agency but have not yet been legally adopted.

We have had, therefore, for many years a window through which to observe adoption practice, and a certain amount of authority and responsibility for improving what we have seen. What we have seen may be typical for the Great Plains States only, but as nearly as we can make out it is not grossly atypical of adoption throughout the country; the children, the parents, the agencies, and the problems are much the same everywhere. The only entirely atypical thing is for a health department to have an observation post because it is generally taken for granted that public health has no concern with adoption at all. This assumption would be considered valid by most professional people, since most of the physicians, nurses, and administrators in public health work have nothing whatsoever to do with adoption from the beginning of a fiscal year to its close.

There are, however, a number of opportunities for public health workers to engage cooperatively with others in this field, if one looks for them. Public health agencies register illegitimate births and write new birth certificates when children are adopted and perhaps there is useful information to be gleaned from all these records. Public health agencies are expert in arranging good medical supervision during pregnancy for the indigent or uneducated mother, and social agencies have difficulties in providing such care for the unmarried mothers with whom they work. The increasing public health interest in perinatal mortality and morbidity could have some bearing on the quality of the children placed in adoptive homes.

Public health workers are, or should be, relatively skillful in statistical analysis and evaluation, something in which child welfare work is not yet strong. They often engage in a multidisciplinary approach to social problems and have enough self-confidence to engage in it freely, which might make them useful

Based on a paper presented at the 1958 meeting of the American Public Health Association.

in adoption practice where social work, the law, medicine, and psychology should work together smoothly. The public health field has been well acquainted with the uses of publicity for a long period of time, while social work only recently has become convinced of its importance, especially in the matter of adoptions.

In public administration, health agencies are older and perhaps more experience than their counterparts in the field of social work. The public health agency is a little cynical about human nature. Skimmed milk will persistently masquerade as cream, and have a high bacterial content, unless standards are established and enforced and frequent inspections are made. This sort of attitude could be useful in adoption work, where the important element of protection to children strictly requires good laws and good law enforcement.

The benefits of an interest in adoption on the part of public health workers would not all flow in one direction. The public health field can learn a great deal about children and the conditions of childhood from child welfare practice, a knowledge which can be used to the advantage of any maternal and child health program. Involvement with adoption practice specifically can lead to a better understanding of certain significant public health problems, such as abortions (both natural and criminal); the incidence and etiology of infertility; morbidity and mortality among illegitimate children; natural mother-child relationships and the development of motherliness; the consequences of maternal deprivation; and the early identification and alleviation of handicapping conditions in children.

The Picture Today

Let us take a brief look at the adoption picture before looking further at ways in which public health agencies might become involved. Professionally speaking, placement of a child for adoption is the intimate and special sphere of the child welfare worker. It lies at one end of a whole spectrum of services to children deprived of parental care and is the logical objective for the child who has no family because his parents are dead, or have deserted him, or have relinquished him because they cannot provide proper care, or because parental rights have been severed by court order.

The social worker's job is to find the right permanent home for a particular child, a home where in all probability he will find love and security and support until he is an adult. The rules for accomplishing this are largely empiric. Until recently there have been, to my knowledge, no properly controlled studies of adoptive placement which would identify the important variables and afford some firm basis for determining practice. Child placement is in fact an art, although considerable research to give it a scientific foundation is underway.

In the case of independently arranged adoptions, almost anybody may substitute for the social worker and her agency setting. Many people feel confident that they can arrange good adoptive placements,[1] and this natural confidence is apparently enhanced by postgraduate training in law, medicine, and theology. The independent placers are usually ignorant of the empiric rules, and rarely make enough placements to be able to work out rules of their own. They think in terms of finding a good child for a particular family rather than a good family for a particular child.

Placement of the child in a family home is a prelude to the very important legal procedure of adoption. The law varies from State to State, but it usually requires that a petition to adopt be filed in probate court by the prospective parents, and that it be accompanied by a consent to the adoption signed by someone who has a right to give consent—either the natural parents or the appropriate social agency. In most States an investigation must be made by a social agency if the child is not related to the petitioners. However, even if investigation shows that the placement is by no means a satisfactory one, as is often the case in independent arrangements, the petition is usually granted anyhow. The courts are unwilling or unable to take the responsibility of removing a child from a home in which he has lived for some period of time.

The Children

The adoption picture is further complicated by the fact that there are about five distinctly different categories of children needing adoption, each with its individual problems and each overlapping the other to some extent.

Category A is composed of healthy, well formed, white babies who are usually illegitimate. The demand for such babies greatly exceeds the supply. The social agency has no trouble in finding homes for such children, but great difficulty in pacifying the would-be parents for whom no child is available. A large percentage of the children in this category are placed by individuals and not by agencies.

Category B, at the other extreme, consists of chil-

dren for whom it is just plain hard to find adoptive homes. These are children with significant mental or physical handicaps, children with major personality disturbances, and children from minority racial groups or mixed racial backgrounds. As short a time as 10 years ago most of such "hard to place" children probably would not have been considered for placement at all. In the last decade social agencies have learned that good homes can be found for them if the responsible agency will exert enough honest effort. Since the effort is always expensive and the price of failure is responsibility for expensive, long-term foster care, there is a tendency to consign these children to placement agencies that are tax-supported.

Category C children are those midway between A and B, without pronounced handicaps but not so young or so white or so attractive as the A babies. These require for a good placement enough work and skill to make the task professionally rewarding. A few of the younger ones are placed independently, but as a general rule these are agency children.

Category D consists of foreign-born children, the majority from European countries. For the most part, they are young and white and healthy, though this is certainly not the case with the children of mixed Negro and Korean racial backgrounds that have been arriving in this country recently. National and international social agencies have made increasingly successful efforts to exercise supervision over intercountry adoptions, but nevertheless many of the usual protections for the child are lacking. Some of these children are adopted abroad by proxy and may suddenly appear in this country without the knowledge of any responsible social agency.

Category E, consisting of stepchildren and children adopted by relatives other than parents, is the largest, the least dramatic, and certainly the most neglected from the standpoint of social control. Nearly half the children adopted in any given year fall into this group. The word "stepchild" has a bitter meaning in the English language, and our society has taken no real action to change its semantic implications. These children receive little supervision in some States and none at all in others. They are sometimes considered the responsibility of the courts that take divorce petitions—which are courts that are seldom provided with social workers.

Is it proper to call any of these children socially disadvantaged? There is not, I think, any yes or no answer to this question. From one aspect, it might always be considered better to be adopted than to be without a family; from another, a bad placement is complete disaster for the child. The question of disadvantage is plainly bound up with the alternatives that are available.

A parentless child is disadvantaged if a good adoptive home could be found for him but is not.

An adopted child is usually disadvantaged by a placement arranged independently if the available services of a qualified agency have been intentionally bypassed or overlooked.

A child placed in adoption by an agency is disadvantaged if the agency's practices are poor or outdated.

If public health agencies can favorably affect any of these disadvantaged children, and particularly if they can help them in ways that other agencies cannot, then public health has a real responsibility. In actual fact, many of these children are being touched by the public health programs for all children, but much more could be done if there was some focusing of the effort.

A Public Health Program

A public health "adoption program" might consist of three main elements: (1) activities designed to make more parentless children available for adoption; (2) activities designed to reduce the frequency of independent placements; and (3) activities designed to improve agency adoptions.

1. Making children available. There are many ways public health agencies might make more children available for adoption. They can help to report illegitimate births promptly and routinely to appropriate welfare authorities, so that no illegitimate child will be overlooked. Routine visiting by the public health nurse might be required for illegitimate babies who leave the hospital with their mothers, a procedure that would keep some infants alive to be adopted at a later day, and at the least would insure that the child does not disappear from sight altogether. Public health nurses and physicians see a good many young children suffering from gross physical neglect as one aspect of gross parental neglect, or bearing visible marks of mistreatment. Such cases should be reported to the authorities. A child's own family is hard to replace, but some parents are hopeless and their children may be better off if placed for adoption.

Residential institutions, especially in the Southwest, contain many young children who are adoptable, but growing less so with each passing month. Public health agencies may not have direct authority

over such facilities, but they can exert powerful moral suasion. In Kansas we have had some success in shaking these children out of the institutions, chiefly by pressing for qualified child welfare services as a necessary part of their organizational structure. When a public health agency informs an institution of its need for social work services, it may be more convincing than when the public welfare agency gives the same advice.

Many children with major physical handicaps could be adopted were it not for the high cost of long-term medical and hospital care. If tax-supported care is available to a child who remains a State ward, but is not available or not freely available if the child is adopted into a family, the public health agency has some obvious responsibilities for straightening things out. Similarly, public health knowledge and skills can be used in preparing handicapped children for adoption at the earliest age possible.

2. Reducing independent adoptions. In efforts to reduce the frequency of independent adoption, educating the public and the professionals is important. In Kansas the State board of health supplies physicians with pamphlets for use with their childless patients to stress the advantages of social agency adoptions. It participates in interprofessional meetings on adoption such as one held by the State medical society's committee on maternal welfare with the heads of the leading child placing agencies in the State. Following this meeting an editorial appeared in the medical society's journal deprecating the arrangement of adoptions by physicians.

It is helpful to have a straight story to tell. The impression is sometimes given that out of every three independent adoptions, one baby turns out to be defective and another is forcibly reclaimed by the natural mother. These are rare occurrences. Agency placements are always to be preferred (1) because they favor the interests of the child, who is helpless, over those of the would-be parents, and (2) because they bring professional knowledge and skill to bear on a crucial event in the child's life. They are not perfect, but they are safer.

Giving birth to an illegitimate baby under social agency auspices might be made less formidable. If, as actually happened in Kansas a few years ago, an unmarried mother is presented with a choice between, on the one hand, spending her pregnancy in a sunny apartment, receiving medical care by a specialist as a private physician, and having first-class private hospital care, and, on the other hand, living in an unpleasant boarding house, receiving medical care in a chilly public clinic, and being delivered in a hospital for indigents, she can be excused for choosing the superior facilities even though these are offered by a lawyer operating independently rather than by a social agency. Moreover, a well cared for, well nourished, comfortable pregnancy is likely to result in a better baby. Because social agencies rarely have enough money properly to underwrite a pregnancy, public health skills can be of real help. In some States, notably Indiana and Connecticut, effective cooperative programs have been developed.[2]

Public health agencies usually have excellent relationships with the hospitals in which most illegitimate babies are born. Hospitals are made uneasy by independent adoptions initiated within their walls and usually welcome advice on how to proceed most ethically with their unmarried maternity patients. For these patients, receiving a written statement of what agency services are available may be more useful than just being handed a copy of "Infant Care" alone, with the compliments of the health department.

The enormous demand for nice babies, which is the basic cause of independent adoptions, could be reduced if more of the childless couples who want children could produce their own. In Kansas, we were able to give agencies assistance in establishing factual criteria for sterility by furnishing outlines for an examination and a list of qualified physicians, and occasionally giving direct consultation. Since nobody really knows how many couples are sterile, or whether sterility is increasing, the subject suggests itself as valuable for study by public health agencies. Better fertility studies will also reduce the incidence of pregnancy after adoption of a child, an event which is not catastrophic but which tends to make things more difficult for the adopted child.

3. Improving agency practices. In attempting to improve social agency practices, public health agencies must of course tread rather carefully. Perhaps the most effective approach would be to offer skill in designing and carrying out carefully controlled cooperative studies of adoptive placements. Such projects might well be underwritten through money available for mental health research, as badly placed children are likely to have a high incidence of identifiable psychological difficulties.

The sum of our knowledge of children is increasing rapidly, and health agencies may be aware of new concepts long before they filter down into social work. In Kansas the State health department was

pressing for early placement of newborns into adoptive families and doubting the reliability of "infant testing" for predictive purposes for many years before these ideas became a part of accepted child welfare thinking. At present we are trying to convince our colleagues in child welfare that one foster mother in a temporary boarding home cannot care for the needs of more than two infants. We have every confidence that time will prove us right.

One of the real barriers to early placement of infants is the widespread supposition that many illegitimate babies who appear normal at birth will prove later to be more or less defective. Most pediatricians would probably favor an opposite theory, that even the ones who appear defective at birth are likely to be quite normal, but pediatricians do not generally have an extensive experience with illegitimate babies as a class. There may be a basis of fact in these misgivings, or there may not be, but no one will be sure until there are comprehensive studies comparing children born within wedlock with those born without. (One reason that we do not have such studies is the secrecy surrounding illegitimacy. In Kansas, one risks a jail sentence if he attempts to inspect birth certificates of illegitimate children.)

Birth certificates can help improve adoption practices by providing information needed to assess the child's hereditary potential. Unmarried parents may disappear from sight, leaving the information on the birth certificate as the only information available for determining the child's hereditary background and the circumstances of his birth. In Kansas the division of vital statistics has spent a good deal of effort obtaining completion of certificates that have been filed with the father's name listed as "unknown." We have only rarely found an unmarried mother actually so promiscuous as to preclude proper completion of the certificate.

Health departments routinely make certain services available to babies and parents who stand to profit by them. It seems fairly certain that adopted children are not apt to fare as well as those born into a family in the usual way. If visits by a public health nurse when a baby first comes home do promote good adjustments, if the "Pierre the Pelican" letters used by many States do help parents understand children, if well-child conferences do indeed bring about better mental and physical health, they should be made available to adopted children. As it stands, the adopted are frequently overlooked because the machinery of the health department gets confused in the absence of specific channels of communication between social agencies, courts, and local health departments. There is no good reason why such channels should not be established.

These possible activities, drawn from the experience of just one State, suggest that the public health field has its contributions to make to adoption practice, even though they are relatively small. With adoptions taking place at the rate of 90,000 a year and the trend ever upward, no health department could be criticized for devoting some special time and attention to this group of children in special need.

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[1] Thornhill, Margaret A.: Unprotected adoptions. *Children*, September–October 1955.

[2] Curtis, Hester B.; deRongé, Alberta: Medical and social care for unmarried mothers. *Children*, September–October 1957.

In human affairs, there are not only the right sides of questions and the wrong sides, there are human dilemmas. Situations arise where, it seems, whichever course is taken great loss or injustice will result. In such cases good human management tries to find solutions which will secure the maximum of gain with the minimum of loss. Imagination and creativeness sometimes have a part to play, as well as good intent.

"The Story of Community Service," Arthur E. Morgan in* Community Comments, *February 1958.

YOUTH PARTICIPATION IN COMMUNITY AFFAIRS

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IN A DEMOCRATIC SOCIETY active citizen participation in all phases of community living is of major importance. Opportunity for young people to participate in community affairs is essential to the realization of this goal. It provides the training ground for the development of mature, resourceful adults capable of participating in a dynamic society.

Spurred to a realization of this relationship by the Midcentury White House Conference on Children and Youth in 1950 and by the increasingly obvious necessity of reinvigorating the institutions of democracy presented by subsequent world events, youth-serving agencies, schools, and civic groups have for the past decade been exploring ways in which young people might take more meaningful responsibility, not only for their own immediate interest but also in areas of concern to the total community. In fact, even before that youth-pervaded conference, during the years of World War II, an awareness of young people's potential for managing their own affairs and working with adults in community activities seemed to be on an upswing. Teen canteens developed throughout the country, with youth and adults functioning together in program planning and policy making. Community youth councils were organized in many places so that a widely representative group of young people could express their opinions, raise questions, and work on special projects of community-wide importance.

Yet the questions are still frequently raised: "Can teenagers really participate with adults?" And, if so, "How?"

Five years ago Y-Teens of the YWCA in 27 cities—6 in the East, 12 in the Midwest, 7 in the South, and 2 in the West—made a simple survey of approximately 3,000 other teenagers, on the question: "Do you think that teenagers have privileges and responsibilities as citizens even though we do not vote?" The interviews took place during leisure hours in neighborhood centers, youth canteens, and "hangouts" among the young people who happened to be there. In one instance a civics teacher became interested and had the survey made in several civics classes.

The overwhelming reply of these 13-to-16-year-olds was "Yes." Many of them cited the fact that the Bill of Rights offers nonvoting citizens the same protection as it offers voters. In regard to their comments the *New York Times* reported: "The youngsters named freedom of speech and worship, educational and labor opportunities, and the use of public facilities such as libraries among their privileges. They predicted that a more liberal attitude by adults toward teenagers would bring them more privileges and responsibilities as citizens." [1]

The questionnaire used in the survey asked further: "What have you done or are you now doing to make your community a better place in which to live?" Leaving spaces for checking *Am doing now* or *Have done*, it listed the following activities:

Take part in traffic-safety projects.

Work in Community Chest and other drives.

Cooperate with other groups in working for better schools (promote bond issues, teacher-education recruiting, academic freedom).

Work as an aid in hospitals.

Serve as aids to group leaders to help with activities for small children in community centers.

Volunteer for other school and community projects (give examples).

Hold a part-time job and function reliably as a worker.

Study the structure and function of government—local, State, and National—and work to enlighten others.

Study to understand the work of the United Nations and work to enlighten others.

Participate with adults in YWCA and community activities.

Take part in international projects (name).

Work with communications media to publicize the worthwhile things teenagers are doing.

The replies showed that in one city all 400 teenagers interviewed checked that they are now working on or had worked on at least one of the community projects listed. In another city the 200 teenagers interviewed checked at least two activities which they had been or were presently engaged in. More than 50 percent of all those interviewed in the survey were now working on or had previously worked on one or more of the following activities: (1) traffic-safety projects; (2) community drives; (3) part-time jobs; (4) government study projects.

Approximately 50 percent were now or had previously taken part in: (1) U.N. study projects; (2) school and community projects other than those listed; (3) community activities, working side by side with adults.

Less than 50 percent were now or had previously worked as: (1) hospital aids; (2) aids to group leaders in work with small children; (3) participants in international friendship and exchange projects; (4) participants in efforts to publicize through the communications media the worthwhile things teenagers are doing.

Enlarging the Scope

As the foregoing shows, most community activities for youth have been of a service nature. Such activities should not be belittled for they help young people to explore vocational avenues, pursue new interests, discover the importance of understanding persons of many racial, cultural, and economic backgrounds, and find the meaning of citizenship. It is important that this traditional approach be retained.

Young people today, however, because of the extended use of the community as a laboratory in education, increased opportunities to participate in conferences, work camps, and international exchange, and the ready store of information available through radio, television, newspapers, and magazines, can effectively enlarge their field of community participation. They need help from capable adults to do so.

Movement in this direction was taken in April of 1958, when 60 teenage leaders met in New York City in a consultation called by the Committee on Youth Services of the National Social Welfare Assembly to discuss youth in community affairs. The young people were asked as consultants to help the committee obtain a view of young people's opinions about ways in which youth is presently participating or might be encouraged to participate in community affairs. In planning the consultation the committee, composed of adult representatives of national youth-serving organizations, sought to create an atmosphere in which the young consultants would be able to express their opinions and feelings freely, leaving the adults to listen, observe, and to serve as advisers on request.

As they talked to each other these young people came to the conclusion that "only a small percentage of youth are participating in community affairs," and they wanted to find out why. They also exhibited considerable concern about adult attitudes toward youth, the problem of understanding themselves, and how to achieve self-respect and status.[2]

Their report records their belief that: "Young people like us *are* interested in community affairs, but we represent only about 10 to 15 percent of the youth of our age. . . . . Another large group, probably 75 percent of all teenagers, could be interested in programs which include community affairs, but 'they need a little push.' . . . Another 10 percent would definitely not be interested. . . . . But even these *could* be reached 'because after all everybody has *some* interest and you can appeal to young people through whatever interest they have.'"[2]

The few skeptics, such as the young man who asked, "why does everybody have to be interested in community affairs—adults aren't?" were far outnumbered by the young persons who expressed the conviction that it was "both appropriate and important for youth to work with others to improve community life."[2]

There were, however, those who registered reservations about the extent to which young people should participate in community activities, pointing out that in these years schooling is most important and nothing should interfere with it.

Thus through directly consulting with young

people themselves youth-serving agencies have been trying to see the strengths and weaknesses in their present programs, as well as new opportunities for enabling young people to take their place *now* in community life.

Contributions of Youth

Giving youth a place in community life is not entirely a matter of training young people for adult responsibilities. Today's adults have much to gain from the process. Says Max Wolff, associate professor of sociology at New York University, "In periods of crisis affecting the fundamentals of society the vision of youth must be blended with the knowledge of experienced elders to create the new basis for tomorrow's social organization. Such a critical period exists today in the American community." [3]

It is well then to take a look at life throughout the United States to see what are the major forces affecting the well-being of communities and then to ask, Can youth help? This does not mean to ignore those needs related to youth per se, such as the ever-present need for additional recreational facilities, but rather to accept the fact that any major public issue in one way or another not only has some bearing upon the degree to which young people can grow to their fullest stature as citizens but may itself benefit from the freshness and frankness of the young.

Among the many problems facing our country today are a number in which young people have a direct stake. In regard to public-school integration, they are the ones who have firsthand experience. Their awareness, insights, and hopes in relation to their own abilities might also be taken into account as plans are developed for improving educational opportunities and school curricula and facilities.

Our Nation's difficulties with other countries might even be eased somewhat if the natural openness of youth and their ability and willingness to see through outward differences to the inner similarities in people could be fostered. A 17-year-old girl, who spent a summer in Germany on a scholarship saw this when she said: "In 2, 3, or 4 years we'll be the airline hostesses, military personnel, trainees for diplomatic service, and tourists. If we could have more opportunities now to get to know youth in other countries who will also be moving into these areas of responsibility, we'd save a lot of time in achieving a wholesome working relationship, which is so essential to real international cooperation and good will."

Recently a group of 17 Y-Teens and 8 adults working on plans for the 1959 National Y-Teen Conference on Youth's Role in National and World Affairs emphasized the importance of young people's finding ways to express the goals of our Nation to the world in other than material aid. They pointed out that urging young people to build their skills in all the arts and languages could make a vital contribution in "presenting to the world the real face of America."

Some guidelines for analyzing how young people might appropriately contribute to any particular project might be found in estimating the degree of ability and knowledge required for various elements of the task; the quality and nature of experience necessary to bring reality to the approach; the abilities and skills needed to accomplish the goal; and the interrelationships that might enhance the work in process and bring the added benefits of good human relations and understanding at its completion.

Some Projects

Young people and adults are already working together in a number of projects to find ways of involving youth in local, national, and world concerns. Several national youth-serving organizations have advisory councils of youth constituents, which meet with national planning groups to evaluate program and participate in the development of new program. The National Council of Churches of Christ in the United States of America included young people as fully accredited delegates in a recent "high level" conference on the church and world order. Y-Teens are now recognized as full members of the YWCA, with opportunity to attend triennial national conventions as delegates. The Michigan Youth Advisory Council, composed entirely of young people, has initiated a program that bears on the well-being of the State as a whole, including projects to promote summer employment for youth; traffic safety; and improvement of the labor, educational, and recreational conditions of migrants.

The Wisconsin Youth Committee for Community Youth Participation, open to all young people through a county-district-State structure, is officially recognized as the channel for the expression of young people's opinions on public affairs. With adult consultation provided by the State department of public welfare the committee attempts to draw youth into community affairs by providing clearinghouse services and by holding an annual State conference for the exchange of ideas and experience. Its State committee, chosen by the young people in district elections, works closely with the Wisconsin

Committee on Children and Youth, a body of adults and young people appointed by the Governor, which has among its responsibilities the promotion of local youth councils. To help such councils inject vitality into adult-youth partnership, the youth members of the Governor's committee have prepared the pamphlet "Youth Participation on the March," [4] containing pointers for successful youth participation with adults in planning.

For several years young people in California have participated in the planning and deliberations of the Governor's youth conferences. The 1958 Conference on Youth Participation in Community Affairs offered an opportunity to discuss a wide range of interests including the family, the school, the church, jobs for youth, the motor age, delinquency prevention, community affairs, accomplishments of youth, and youth fitness.[5] The report of the conference indicates that youth and adults entered freely into discussion and that there seemed to be acceptance of the need for partnership on the part of each. Reported one work group: "Youth and adults have something to share with each other. Neither group has all the answers. The important thing is developing good relationships and moving together with mutual trust and respect."

Principles for Success

As groups in towns and cities work to achieve more extensive and vital youth participation in community affairs, it is well to consider some of the factors that may help and those that may hinder their efforts. These might be identified by a consideration of the following questions:

1. What experiences in family living, school, church, and community groups will help young people become ready and willing to take part in the real issues of living?

2. As young people are helped to participate in community affairs, what are their motivations and expectations?

3. If young people seem unwilling to take responsibility in various phases of community life, what is the basis for their reluctance? What can be done to help them discover their own potential for participating in community life in a way that will have meaning for themselves and be of benefit to the community?

4. If adults invite youth to participate, what are the adult motivations and expectations?

5. As youth participates, how much should adults expect of them?

The role of the adult—singly and as an identifiable segment of the community—is an important key in the discovery, release, and utilization of the skills and potential of youth. It is important for those promoting adult-youth partnership to understand and accept some of the natural breaches between adolescents and adults, and find ways for them to work together in spite of these. The natural idealism and enthusiasm of youth along with the fact that most young minds are as yet uncluttered by the fears and prejudices that beset adults can bring an effective enthusiasm, not usually supplied by adults alone, to the tackling of many important tasks. Adults working to bring youth into meaningful participation in community affairs need an understanding of adolescent behavior, hopes, and aspirations, as well as an understanding and acceptance of themselves and their own strengths and limitations. They also need to have a knowledge of the elements at work in the community that enhance or hinder effective relationship, and to possess skill in helping people to work together in groups.

In searching for methods for promoting youth participation some groups may turn first to the formal organization of a youth council. With on-

A San Francisco high school girl leads a nursery school singing group to the accompaniment of the teacher's guitar. Work with children is a popular activity among teenage girls who volunteer to serve their communities.

going staff and adequate adult leadership, such a group can be an effective channel for young people's efforts, relating their concerns to those of the community at large. However, creation of a council does not have to be the first and only step toward increased youth participation in community life. A conscious effort ought to be made by both adult and youth leaders to examine the activities in which young people are already involved in relation to their effectiveness and satisfaction for youth and for the community. In the process new avenues of interest may be opened as unmet needs become apparent.

After such a review of the current scene young people and adults together might make a careful selection of some immediate goals as well as a long-term plan for including youth regularly in all phases of community effort and concern. Then a group of young people and adults, representatives of various youth and community groups, might consider when, how, and at what points young people of various ages—junior or senior high school or college age—can and should be given the opportunity to participate in specific efforts.

In its pamphlet, previously mentioned,[4] the Wisconsin Youth Committee cites several basic principles for successful youth participation in program planning:

In predominately adult groups there must be enough youth to lend support to each other.

No youth group can function satisfactorily without mature adult support and guidance.

When youth are sitting in with adults, extra time must be taken to keep the youth informed.

Adjustments must be made in meeting times, places, and methods when youth are being brought into adult programs—but also the inverse is true.

Whether youth or adults, special effort must be made to stay in contact with the people represented.

Youth must assume responsibility for showing adults what is desired of them. Sometimes, the nonparticipation of adults is a conscious effort not to take over.

Time must be allowed for both planning and evaluation if youth are going to learn by participating.

"Adults need to pave the way for youth participation, but the real effectiveness will come when the individual youth accepts his privilege and assumes his responsibilities," the pamphlet predicts.[4]

A look at communities generally does not show the vital quality of youth participation that is needed to pour new strength into our democratic way of life. Too often youth participates only in a phase of experience which has very little chance of penetrating or changing the total community. However, the fact that in the past few years young people have been taking more and more responsibility for various community drives and are serving as volunteers in many community services may indicate next steps in participation. As young people ask to help with community projects, adults must be willing to accept their offer and provide the guidance that will enable them to take responsibility meaningfully. A scheme for making ways of participating in community affairs available for all young people would provide widespread training so that the leadership necessary for dealing with the myriad problems of our society would be encouraged to emerge.

"Participation in the democratic sense is a complicated art;" writes Max Wolff, "only a few are born masters, but many, most of the people, can learn it. The best method of learning is active and continuing practice. Three conditions must be fulfilled to induce individuals to try themselves out as participants. They must be sure that: they are really welcome by the coparticipants; they are asked to participate because of their qualifications as coworkers; their participation will be a meaningful contribution to the goal of the cooperative activity." [3]

With proper encouragement, youth can be a positive force for bringing about the changes for good that a dynamic society must constantly seek.

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[1] *New York Times,* Monday, April 19, 1954.

[2] National Social Welfare Assembly, Committee on Youth Services, New York: Report of consultation on youth in community affairs. 1958.

[3] Wolff, Max: Youth must participate. *YWCA Magazine,* February 1959.

[4] Wisconsin Committee on Children and Youth, Madison, Wis.: Youth participation on the march. March 1958.

[5] Department of the Youth Authority, Sacramento, Calif.: Report of Governor's conference on youth participation in community affairs. February 1958.

What questions have been engaging the attention of research workers during the past ten years?

A DECADE OF RESEARCH CONCERNING CHILDERN

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WHAT CAN BE DONE for retarded children? Does parent personality play a part in schizophrenia? How can children get better health services? Can delinquency be predicted and, thereby, prevented? Can adoptive homes be found for the older children, handicapped children, Negro children? What should be done for the gifted child? Do tranquilizing drugs have a place in the treatment of children? How can the teenager become a safe driver? What are the effects on children of racial desegration in the schools? What factors influence physical growth? How do children react to hospitalization and surgery?

All these questions and many more are being asked today by persons concerned with services for children. Many are being answered through slow, careful study. And, as each question is answered, investigators move on to the next question. Seemingly a slow process this, but a look at 10 years of research reported to the Children's Bureau Clearinghouse for Research in Child Life indicates that headway has been made toward solving some problems. Some questions have been so well answered that the problem and its solution have become history; other investigations have proved futile and been abandoned.

The staff of the Clearinghouse has often wondered if a close inspection of reported research would indicate any trends, startling developments, or a picture of step by step but undramatic accomplishment. The Clearinghouse has now been in existence for 10 years, collecting information on on-going studies concerning children and reporting on them in its publication, *Research Relating to Children.* It seems an appropriate time to stop and look at the several thousand studies reported since 1948.

The studies currently included within the scope of the Clearinghouse and hence those considered in this article are all in the following areas: child growth and development—physical, mental, emotional; personality—"normal" and disturbed; school life—achievement and adjustment; services for children—health and welfare; and the social and cultural factors that affect child life.

This survey of 4,415 studies does not include consideration of purely medical studies, master's theses, reviews of published materials, or administrative studies of such matters as school construction, local service needs, and the like. Some such studies were included in early issues of *Research Relating to Children*, but since the coverage was always incomplete, any generalizations drawn from them would be invalid. The Clearinghouse no longer attempts to collect such reports but limits its coverage to the areas which can reasonably be covered and which, it is hoped, will be of general interest to the various "consumers" in all fields concerned with the development of children.

For convenience, the studies have been grouped into those reported in three periods: 1949–51—1,601 studies; 1952–55—1,243 studies; 1956–58—1,571

studies. They are dated according to the year in which they were reported, although some of them have continued over several years.

Now, what has been happening in the years since 1948?

Mental Retardation

The most obvious, and perhaps most gratifying, trend to be noted is the increase in research on mental retardation. Nearly 4 times as many studies concerned in some way with mental retardation were reported to the Clearinghouse in the years 1956–58 as in the years 1948–51—151 in contrast to 42. Much of this increase is due to the large Federal sums appropriated for research—mostly disbursed through Office of Education contracts with State departments of education and with universities. The National Institute of Mental Health also continues to spend a considerable amount supporting research in this field. But the Federal legislation which made the funds available was a reflection of the increased interest on the part of the public—especially parents, educators, and professional health and welfare personnel who saw the need of more knowledge about this problem.[1]

Not only has the amount of research increased, but the direction has changed. Of the 42 studies reported in the earlier years, 10 were concerned with the effects of glutamic acid on raising the I.Q. Not a single study on glutamic acid has been reported to the Clearinghouse since mid-1950. Since the early research effort found no evidence of the treatment's effectiveness, investigators have turned their attention to other, perhaps more promising, paths. Increasing attention is being given to causes of retardation, with emphasis on infections in pregnancy, birth injury, and most recently to metabolic disorders, such as phenylketonuria, which are associated with retardation. There is also much current experimentation with the effects of tranquilizing drugs on mental development, on academic achievement, and on the behavior of some types of mentally retarded children.

One would almost think that the tranquilizers are now being administered to everyone for everything. They are being studied in relation to their effects on perception, on stuttering, on physiological functioning, on enuresis, on fantasy, on learning, on reading, and on the motor behavior of cerebral palsied children. Much of value may come out of this work in psychopharmacology. The results will determine whether research along these lines will continue at such an enthusiastic level over the coming years.

With such a large amount of support for research in mental retardation coming from an educational source, it is not surprising that an abundant interest is being shown in education for the retarded. Close attention is being given to how and how much such children learn. And there is an increasing inclination to delve into the possibility that rather severely retarded children can be educated and that children formerly considered hopeless are trainable in a variety of self-help ways. For these children and for their parents this research effort is providing ever more hope.

Education

At the other end of the mental scale, reporting on research on the gifted has increased from 5 studies in the first few years of the Clearinghouse (1949–51) to 30 in recent years (1956–58). The volume of these studies is still not large but will no doubt increase as the country more and more demands the best brains to carry forward the Nation's business. Sputnik I played its part in stimulating research on gifted children, but even before October 1957 educators had begun to consider how to identify the talented, how best to educate them, and how to hold them through high school and send them on to and through college.

The picture of research on the educational process—omitting special education for the gifted and the retarded—has not changed greatly, although research in special education for all kinds of pupils has increased, not only for those children handicapped by inadequate vision or hearing or other physical defects, but also for the socio-economically handicapped such as migrant and non-English-speaking children.

After the Supreme Court of the United States handed down its decision that racial segregation in public schools is unconstitutional, it was to be expected that there would be research on the effects of desegregation in the schools. One study was reported within the year. Nine additional studies have followed. However, the psychologist Stuart Cook believes that much more research can and should be done while the laboratory set-up is unique and well-nigh perfect, with communities at all stages of progress.[2] The need is not only in the psychological field, but equally so in sociology and education.

Child Development

Work on aspects of physical growth has declined somewhat in amount and continues without notice-

able change in direction. Research concerned with the effects of nutrition on growth appears to have declined, but this may represent poor coverage by the Clearinghouse rather than actual fact. Work on mental growth—aside from the gifted and retarded—has about doubled in volume, with most of the increase going to studies of learning: How does it take place? How can it be increased? What factors of environment or personality retard it?

Interest in special aspects of personality development in the child, such as oedipal development, oral habits, insecurity, moral character, has somewhat declined. On the other hand, there appears to be increased interest in interaction within the family, particularly between parent and child, leading to emotional disturbance. Disturbances in personality have been receiving increased attention over the years. Twice as many studies have been reported in recent years on schizophrenia alone. More and more concern is being shown with treatment—evaluating the effects of residential treatment, experimenting with drugs and with day care treatment.

In another area of great interest these days—juvenile delinquency—there has been no change in the number of projects reported but some change in the type of research investigation. There is a sustained interest in the possibility of predicting delinquency. There seems to be less concern with socio-economic conditions as causes of delinquency—for example, low income, poor housing, ethnic background. There has also been a trend away from study of the effects of individual therapy toward a look at the effects of groupwork, the effects of street corner workers, and, most recently, the role of courts, probation and parole officers, and detention workers.

Services

In nearly all areas of research on services for various categories of children, there seems to be a trend toward sharpened focus and more sophistication. How many children with what kinds of problems need what types of services? There is less dependence on merely surveying the numbers of children on parole, children receiving aid to dependent children, children being seen in well-child conferences. We find researchers looking for the answers to such questions as: Can a parole officer do a better job if his caseload is cut down to a half, or a third? Why do some families continue to receive public assistance while others drop off the rolls? Why do parents not keep their appointments at a well-child conference? There continues to be a certain amount of head counting, of course, because there is much that is still not known: What is the actual incidence of illegitimacy? How many children need protective services? How many are receiving them? Through what avenues? What are the gaps in services?

The Clearinghouse coverage of research in the area of health services has never been complete. Therefore, it is hard to judge trends in this broad field. Two changes in respect to health services are, however, quite dramatic. In 1949 and 1950, 12 studies were reported on tuberculin testing in health departments and in schools. In 1958 only two such studies were reported—reflecting progress toward the solution of this public health problem—with new research directed not toward how good is the test, but how can it be applied to all children. Another public health measure that has shown a definite pattern is water fluoridation—beginning with seven studies reported in 1949, five in 1952, five in 1955, tapering off to one in 1958—again evidence that an answer has been found in regard to the effects of fluoridation and it is now up to the practitioners to use the knowledge gained.

In welfare services no obvious changes have occurred. This is probably due, perhaps inevitably, to the fact that studies in the social service field are directed essentially toward recommendations for social action and toward improvement of services. There was and is a fair amount of research interest in foster family care, in availability of child welfare services, in characteristics of families receiving aid to dependent children. For a while research activity seemed to have lessened in such areas as adoption and day care of children, but our "grapevine" suggests that investigators are returning to the problem. Knowledge about day care is of increasing urgency in view of the fact that in March 1958 there were 7,494,000 married women in the labor force with children under 18 years of age—an increase of 62 percent over 1950. Much effort continues to go into surveys of needs for services—for unmarried mothers, children in their own homes, youth groups. There appears to be more current interest in personnel needs: What makes a good houseparent? How can an institution hold on to its staff? What is the role of case aids in easing the workload of professional workers?

The general picture of research activity in the welfare field is not impressive in size, so far as reports to the Clearinghouse show. The number of studies reported continues to be rather small. This is prob-

ably due to the fact that it is difficult to obtain good coverage outside of formal research centers and universities. Many welfare agencies undertake short-term projects from time to time, which are usually completed before the Clearinghouse hears about them. Therefore, the Clearinghouse is not in a good position to comment on either the quantity or kinds of social service research.

Suggestions for Future

Any review of research leads naturally into the temptation to suggest possibilities for future research. It is probably not appropriate that the Clearinghouse staff should venture very far in this direction, except in areas which are of particular concern to the Children's Bureau.

So from discussions with Children's Bureau specialists the following possibilities emerge:

Mental Retardation. While research effort in mental retardation has increased so dramatically, there is still much to be done. The current emphasis on special education and other aspects of schooling is certainly overdue and should provide some of the answers that parents and educators need. But answers in other areas are also needed.

We know too little even yet about the seemingly simple matter of measuring intellectual ability. The tests now in use measure only a narrow range of abilities and are not always dependable in the little they do measure, being affected by cultural differences, test anxiety, and other factors. We also need to know more about factors which may contribute to retardation—socio-economic differences that affect adequate functioning, psychoses which may cause behavior suggestive of intellectual limitation, individual differences in temperament that may affect functioning and adjustment. Much might be done through longitudinal studies of growth and development which would help to guide parents and teachers of retarded children, if an adequate theoretical base could be laid. It would also help those who work with retarded children and their parents to know more about how such children affect other members of their families, how parental attitudes affect these children, and how community attitudes toward them affect the total family constellation.

Delinquency. In delinquency research the drift away from investigating socio-economic causes may be a mistake. Journalists, legislators, and a dozen kinds of individuals often claim to know the specific causes of delinquency. It seems important to obtain more solid information than we now have about whether maternal employment, dropping out of school, and the passing of the woodshed are really factors in causing delinquency. It seems necessary to know causes in order to prescribe better treatment. It is certainly necessary to validate the techniques for delinquency prediction so that special efforts to help will be directed to those and only those "pre-delinquents" who need it.

Much time and money and enthusiasm go into "reaching out" services and baseball equipment and curfew laws. It would seem essential to find out which approach works with what kinds of children. We also need to find out all we can about the types of persons having contact with children who affect them for better or worse—policemen, teachers, social workers, doctors and nurses, even shopkeepers—with consideration of how they might be better prepared for the roles they must play.

Health. States and local health departments are often waiting upon increased knowledge of casual factors and incidence of disease or disability so that they can institute preventive programs and provide better services for all children. What are the effects of radiation from X-rays in a shoe store or a dentist's office? What other sources of radiation are affecting children? Does the usual school physical examination really uncover serious health problems? If not, what constitutes a good examination, good enough to be useful and cheap and easy enough to be practical? Are the programs in maternal and child health and crippled children's services actually raising the health status of our children? How available and how good are medical services for children in foster homes, rural children, children in the slums?

Welfare Services. In the broad area of welfare services there is much we need to know. To date, there has not been the amount of systematic, controlled research in this field that has been carried out in other areas. Welfare services continue, as they must, on the basis of common sense or tradition. But more validated answers are needed at all levels.

Accurate "base" statistics are still needed. For example, until we know how many children need special types of care, we have no realistic base for planning. Are they rural children, slum children, or all children?

To improve social agency practice, we need to have more rigidly designed and better replicated studies to test the effectiveness of current practice. On what bases do caseworkers decide whether a child should be placed in a foster home or in a group care

facility, or remain in his own home? Can these be made more objective? How successful are agency adoptive placements as contrasted to independent adoptive placements? What are the identifiable characteristics of children and adoptive parents who have achieved a successful adoption? What are the presenting problems of adopted children in psychiatric clinics? What of unmarried mothers? Who are they? Why are they? What needs to be done for them?

Are neglectful parents different from other parents—quantitatively, qualitatively? What does change of environment mean for children—moving from the country to the city and from the city to the suburbs? What do they gain and lose?

Another level at which answers are needed is administration. Does the form of agency organization affect the quality of services? What is the effect of trained and untrained personnel? How does turnover of staff affect services? Why is there turnover? Is it greater or less than in other service fields? While attempts are being made to answer some of these questions about staff turnover [see page 154], there is still much to learn.

Are there principles of administrative and fiscal management which can be applied to welfare agency administration? How can the gap between service people and budget people be bridged? Between service people and the public?

Parent Education. Cutting across all of these areas is the sprawling, often ill-defined field known as parent education. What, in 1959, is parent education? Who is doing it? Who should be doing it? Can parent educators be trained as such or is parent education a set of special skills to be added onto professional training in another field. Does parent education promote parental anxiety or parental competence?

Are expectant parents ready for the type of help a nurse might give them in preparation for family living? What cultural factors affect the readiness of parents of delinquent children to accept what the social worker can offer? When can parents of a mentally retarded child accept the necessary counseling from a doctor? How can we evaluate present efforts to educate parents?

These are some of the kinds of questions that practitioners need to have answered. When they and others like them have been answered, we can confidently predict that there will be twice as many asked.

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[1] Garrison, Mortimer, Jr.: Research trends in mental deficiency. *Children*, January–February 1959.

[2] Cook, Stuart: Desegregation; a psychological analysis. *American Psychologist*, January 1957.

. . . We fall into serious error when we define modern science as pure objectivity, totally untouched by intuition or recognition of the human equation. Such a concept is fantasy, and it is fictional. When it is applied in the field of human welfare it results in quick generalizations which set limits on the potential of human beings. Institutions are crowded with people who have been declared hopeless on the basis of a so-called scientific judgment. Can we as social workers surrender all responsibility for struggling with what others have called impossible? For the missionary scientist, the heart has been known to do the leading. The secrets of success are in the heart as well as the mind.

Robert H. MacRae in his presidential address to the 1959 annual forum of the National Conference on Social Welfare.

An essay-review . . .

ASSESSING EFFORTS TO PREVENT DELINQUENCY

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THE MARCH 1959 issue of *The Annals*, "Prevention of Juvenile Delinquency," describes 14 action programs mainly of a demonstration or experimental project type.[1] All these programs are geared to preventing and controlling delinquent behavior. But very few of these reports define exactly what it is that they are trying to prevent. Lacking a definite target, they have difficulty in assessing how close they are to or how far they are off their mark.

It is assumed that the projects selected for presentation and assembled in this volume include the better and more scientific, hence more notable, research endeavors. Conspicuously absent in this series of papers is any reference to recent research efforts to prevent delinquent behavior through early identification of children who are vulnerable, exposed, or susceptible to the development of norm-violating behavior. Of course it may be that these preventive measures have already been publicized beyond their scientific limits, so that their omission may not be so much an oversight as a matter of quality control.

When the action programs and experimental studies reported in this volume are stacked against earlier accounts of similar ventures as compiled by the Gluecks in *Preventing Crimes: A Symposium* (1936)[2] or against the more recent and more critical evaluation of selected delinquency prevention programs by Witmer and Tufts in *The Effectiveness of Delinquency Prevention Programs* (1954),[3] the reader can sense how far research workers and program planners have come. Improvements can be seen in the research design, in the theoretical conceptualization to be found in some reports, but mostly in the sophisticated style of research writing with its self-conscious awareness of the usual limitations in experimental design involving the classical problems of adequate controls and of evaluation. What is still lacking in almost all reports, as the editor points out in her foreword, is precision and validity in the evaluation processes.

True, as Dr. Witmer makes clear, not all the projects reported on in the volume were selected on the basis of having included the undertaking of scientific evaluation. Some were purely action programs of a creative nature, which the reporters frankly assess on the basis of impressions unfounded in any evaluative methodology. Still the missing keys to scientific determination of the value of any program or community effort to prevent delinquent behavior are precision and validity. However, this volume gives testimony that most (but not all) project reporters have learned to write with scientific restraint and to acknowledge openly the technical limitations of their studies.

The Evaluation Barrier

If these studies collectively point to any one conclusion, it is that the program planners and research workers have not yet succeeded in breaking the evaluation barrier to enable us to say that certain planned experience, when carefully engineered, really can prevent delinquent conduct. The reporters of some of the studies, such as the Chicago Area Project, tend to evaluate their efforts on the basis of the meticulousness in carrying out the program activities according to the concepts of the theory on which the program was built. In this appraisal, if the rationale and assumptions are valid and if the action program is managed and executed in accordance with the stated hypotheses, the tendency is to pronounce the study effective. But this, as the reporter himself

explicitly recognizes, is far from scientific validity.

In other reports, "The Effectiveness of a Boys' Club in Reducing Delinquency," by Roscoe C. Brown and Dan W. Dodson, and "The Effects of a Revised School Program on Potential Delinquents," by Paul Hoover Bowman, the authors, though noting that definitive answers are precluded by the limitations of their methods, strain to assess effect by utilizing peripheral data. Still other project reports such as "The All-Day Neighborhood Schools," by Adele Franklin, and "Delinquency Prevention Through Revitalized Parent-Child Relations," by Ruth S. Tefferteller, describe their results through the use of anecdotal or selected case study data. These reports find values in their programs through a process more subjective than objective.

Another overall impression gained from reading through this series of action programs and research effort is the clear focus on the community, the neighborhood, the gang, and the family as the locus of much of the problem of rule-violating behavior. This is in sharp contrast to earlier tendencies to lean heavily in the direction of the child guidance clinic and therapeutic counseling. Instead of focusing on the delinquent or predelinquent (the latter is never defined, and in one report is renamed a semi-delinquent) in a one-to-one relationship, almost all projects work through the milieu—whether this be the family, school, boys' club, work camp, or street corner. This represents a promising change and a much needed shift in the direction of the cultural and subcultural forces that frequently generate and reinforce delinquent conduct.

Some High Spots

A number of the reports—particularly the 25-year assessment of the Chicago Area Project by Solomon Kobrin, the street corner group work in the Boston Delinquency Project by Walter B. Miller, and the group therapy program with the Navy and Marine offenders within a closed community by J. Douglas Grant and Marguerite Q. Grant—show a high order of theoretical conceptualization as a base on which to set the action program. These directors provide clear rationales for their studies. In other reports, however, the reader must infer from the nature of the activities described the basic definitions and hypotheses on which the program rests. These need to be stated explicitly.

There is a refreshing contrast to "all good and all effective" reporting in the brief but factual summary by Antoinette Fried of the difficulties and failures, as well as some good results, met in the work camp program with potential delinquents in Newark, N.J. Rare indeed in these days of self-reporting and subjective writing is a careful documentation of defeat. But important lessons can be drawn even when few delinquents are saved, if observations are made scientifically and if interpretations are carefully drawn.

Some research studies apparently never close. Joan and William McCord report another extension of the much analyzed Cambridge-Somerville Youth Study. Delayed effect of the personal help given to the experimental group as measured against the unaided controls has been further appraised through a careful check of the subsequent records of 253 treated boys and 253 matched controls. The investigators reaffirm previous findings that the Cambridge-Somerville Youth Study failed to prevent law-violating behavior.

One satisfactory attempt at evaluation in this series can be found in the report of the laboratory-like experiment conducted by the Grants in the treatment of nonconformists in the Navy through group dynamics. In this project the most precise research design and appraisal methodology were conceived and carried out within the confines of a rigidly controlled environment of a correctional institution operated by the armed services. Such controls are not so readily established within an open community.

Whence comes the direction and the financial support for the prevention programs described in this volume? Judging from these reports, the private foundations and the National Institute of Mental Health are godfather and godmother to most of the research being undertaken. Many of the research and demonstration programs described are directed by persons connected with universities or private organizations and agencies. Conspicuously absent are reports of research planned by municipal and State-supported institutions and agencies such as youth service boards, juvenile courts, and child welfare agencies. It may well be that persons working in these tax-supported units are busy coping with the delinquency problem and have little time or inclination to fuss with prevention or experimentation, or their job descriptions may not include research activity in regard to prevention.

Steps Toward Improvement

All the reports in this volume argue for better evaluation. Improvements in scientific appraisal will come only after the research workers define more precisely what constitutes a predelinquent

(semi-delinquent or potential delinquent), after they spell out exactly what they are trying to prevent, and after they explicitly state the constructs within the rationale of their studies. Several of the reports indicate that a good start in one or two of those directions has already been made. For example, Kobrin, Miller, the Grants, and Eva Rosenfeld have set down their hypotheses, definitions, and assumptions.

If the first step of definition can be cleared, the next job will be to determine the most appropriate technique for gathering data most relevant to the specified goals. The third step will involve the construction or refinement of appropriate and promising measures for gathering significant data. The last step will demand a check for validity and reliability of the data-gathering technique prior to its use. In short, the building of valid and reliable evaluation tools and techniques, assuming we know our specific goals and targets, still represents the major task to be faced. This may call for a special research study in itself. It is at this point that research effort and monies need to be invested.

With one notable exception, the projects in this volume represent short-term, even abortive, efforts at delinquency prevention. Some of them should be extended and tested on a long-term basis. Many of these programs can be and should be tested by replication. As they now stand, many of them add something to the growing fund of concepts concerning prevention and control of delinquent behavior.

No one report in this volume—nor even all the reports together—will answer the current demand for sure methods of preventing delinquency through communitywide or statewide programs. However, in the midst of the wasteland of opinion and talk, these reports represent a refreshing oasis of experience, though much of it remains still to be tested and verified.

[1] Witmer, Helen L. (issue editor): Prevention of juvenile delinquency. *The Annals*, March 1959. (American Academy of Political and Social Science, Philadelphia.) $2 paper bound; $3 cloth bound. 213 pp.

[2] Glueck, Sheldon and Eleanor (editors): Preventing crime; a symposium. McGraw-Hill Book Co., New York, 1936.

[3] Witmer, Helen L.; Tufts, Edith: The effectiveness of delinquency prevention programs. U.S. Department of Health, Education, and Welfare. Children's Bureau Publication No. 350. 1954.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

HOW MUCH AFFECTION? 20 minutes; sound; black and white; purchase.

Shows how feeling between boys and girls develops an intensity that is sometimes difficult for them to control; suggests how young people can be helped to deal with this problem.

Audience: High-school and junior-college classes; mixed groups of teenagers, teachers, and parents.

Produced by: Crawley Films, 1958.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N.Y.

WHEN SHOULD I MARRY? (Marriage and Family Living Series.) 19 minutes; sound; black and white; purchase.

Presents some of the questions young couples need to consider before deciding whether they are ready for marriage.

Audience: High-school students.

Produced by: Crawley Films, 1958.

Distributed by: Medical Arts Productions, 414 Mason Street, San Francisco.

MAKING A DECISION IN THE FAMILY. 8 minutes; sound; black and white; purchase.

Raises the question—as the basis for audience discussion—of whether a father and mother were right in insisting that a teenage daughter should break a coveted date in order to attend a cousin's birthday party.

Audience: High-school students; parent-teacher and church groups.

Produced by: National Film Board of Canada, 1958.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N.Y.

HELP FOR YOUNG HEARTS. 14½ minutes; sound; black and white; purchase or rent.

Emphasizes the importance of prevocational and vocational counseling for children with damaged hearts.

Audience: Parents of children who have heart disease; professional groups that work with such children.

Produced by: Potomac Films for American Heart Association, 1958.

Distributed by: American Heart Association Film Library, 267 West 25th Street, New York 1, N.Y.

CONGENITAL HEART DEFECTS. 9½ minutes; sound; color; purchase or rent.

Explains the underlying physiology of five common congenital heart defects.

Audience: Staffs of crippled children's agencies; medical and nursing students; parents of children with congenital heart defects.

Produced by: Churchill-Wexler Films for American Heart Association, 1958.

Distributed by: American Heart Association Film Library, 267 West 25th Street, New York 1, N.Y.

BOOK NOTES

THE CHILD WITH A HANDICAP; a team approach to his care and guidance. Edited by Edgar E. Martmer. Charles C. Thomas, Springfield, Ill. 1959. 409 pp. $11.

This collection of papers, planned to help professional workers and parents to join with others in helping children with various handicaps, includes discussions of the place of various sources of help for the child and his parents, written by a pediatrician, a mother of a retarded child, a psychiatrist, a social worker, a teacher, a representative of an adoption agency, and a counselor in medical genetics. Other chapters are devoted to each of a number of types of handicapping conditions, including: amputations; cerebral palsy; congenital heart defect; convulsive disorders; diabetes; emotional disturbances; mongolism; progressive muscular dystrophy; nephrosis; poliomyelities; cystic fibrosis; rheumatic fever; and disorders of vision, speech, and hearing. The editor is the past president of the American Academy of Pediatrics.

DESEGREGATION—SOME PROPOSITIONS AND RESEARCH SUGGESTIONS. Edward A Suchman, John P. Dean, Robin M. Williams, Jr., with the assistance of Morris Rosenberg, Lois Dean, and Robert Johnson. Anti-Defamation League of B'nai B'rith, New York. 1958. 128 pp. $2.

This book, according to the authors, is intended mainly as a stimulant to research and as a suggestive guide to action in racially desegrating the public schools in accordance with the Supreme Court decision of May 1954. The authors summarize present social science knowledge relating to school desegregation as a social process and suggest what that knowledge implies for the actual course of desegregation. They warn, however, that "only in combination with specific knowledge of a local community setting" should their suggestions be used as directives for action.

Part 1 of the book presents a number of general propositions about six aspects of the American social scene and their implications for the desegregation process: social stratification; power in the community; public opinion and propaganda; interaction and communication; prejudice and personality; and the minority community. Part 2 evaluates a number of approaches to research in the light of their past and present success in the field of intergroup relations and suggests examples of needed research and research methods.

The authors are professors of sociology at Cornell University.

CURRENT CONCEPTS OF POSITIVE MENTAL HEALTH. Marie Jahoda. Joint Commission on Mental Illness and Health, Monograph Series No. 1. Basic Books, New York. 1958. 136 pp. $2.75.

First in a series of monographs reporting a national mental health survey, this book, written by a psychologist, analyzes various assumptions as to what mental health is other than absence of mental illness. Among other criteria discussed are: attitudes toward self; self-actualization; integration of self-perception and growth; autonomy; perception of reality; and environmental mastery. Discussing the possibility of there being a diversity of types of mental health, the author urges that more research be carried out on specified mental health concepts and offers suggestions on methods for taking the next steps.

A concluding chapter, contributed by Dr. Walter E. Barton, presents the "Viewpoint of a Clinician" who works on the assumption that the "absence of health" and the "presence of illness" necessarily coincide.

REHABILITATION; a community challenge. W. Scott Allan. John Wiley & Sons, New York. 1958. 247 pp. $5.75.

A broad view of the services and objectives of a comprehensive program for rehabilitation of the handicapped is presented in this book, written by the chairman of the Rehabilitation Council. Addressed chiefly to persons concerned with community planning in this regard, it includes discussions of the tools of rehabilitation, the roles of the various members of the rehabilitation team and of the various types of facilities involved in rehabilitative efforts, legislative authority for rehabilitation programs, the costs and financing of rehabilitation, and planning at all levels from local to international.

Among various steps listed by the author as important in such planning are: weaving the pattern of rehabilitation into the practice of medicine; planning for adequate rehabilitation facilities; integrating public and private programs; recruiting and training personnel; improving legislation to include specific provision for rehabilitation; gearing insurance and health-plan programs toward rehabilitation; encouraging community acceptance of all the handicapped; maintaining flexibility of programs to meet changing disability needs.

DEVELOPMENTAL POTENTIAL OF PRESCHOOL CHILDREN; an evaluation of intellectual, sensory, and emotional functioning. Else Haeussermann. Grune & Stratton, New York. 1958. 285 pp. $8.75.

A method of demonstrating a neurologically handicapped child's possibilities for development is described in detail in this manual, written for psychologists, therapists, teachers, and others concerned with planning the education and training of children so handicapped.

Unlike a standard intelligence test, which measures children's abilities in comparison with the abilities of other children of the same age, the "educational evaluation," as described by the author, analyzes the child's functioning in relation to his own unique pattern of learning and provides results that can be used as a basis on which to plan his educational and training program. The evaluation is made through a structured interview between a handicapped child and a clinical psychologist, in which the psychologist works to motivate the child to reveal the level and quality of his comprehension.

The author is educational consultant in the division of pediatric psychiatry, Jewish Hospital, Brooklyn.

HERE AND THERE

Staff Turnover in Social Agencies

The Children's Bureau recently completed analysis of data on professional staff losses in child-welfare and family-service agencies during 1957. The study was carried on with the cooperation of the Child Welfare League of America and the Family Service Association of America. Participating agencies were the member agencies of these two organizations (except a few nonservice agencies) and the public child-welfare agencies in all States. Highlights of the findings:

1. During the study year, professional staff in the participating agencies averaged 10,328 employees (includes full-time staff only in the child-welfare agencies; full-time and a few part-time staff in the family-service agencies). Of this number, 2,876 employees, 28 percent of the total, left their jobs during the study year. For caseworkers, the average separation rate was 34 percent. Of the total separated, over 70 percent resigned; 9 percent went on educational leave.

2. Basic reasons for resignation of full-time staff (reported in confidential questionnaires by the employees themselves and, in separate questionnaires, by the agencies) have already been tabulated for the 1,600 resignees who were on duty in the participating agencies at the beginning of the study year. Among the five leading reasons reported by both agencies and employees, were: to accept the offer of a better job; moved from community; maternity; and inadequate salary. Agencies also ranked "demands of the home" among the five leading reasons; employees, "dissatisfaction with supervision."

3. The leading basic reasons for resignation reported by men were: to accept the offer of a better job; inadequate salary; and lack of advancement opportunity—accounting, alone or in combination with other reasons, for 70 percent of the resignations of men. Dissatisfaction with supervision, professional education, moved from community (not job-related), and dissatisfaction with program policies of the agency accounted for 19 percent.

4. The five leading basic reasons for resignation reported by women, accounting for two-thirds of their resignations, were: moved from community (21 percent); maternity (17 percent); to accept the offer of a better job (16 percent); dissatisfaction with supervision (11 percent); and demands of the home (9 percent).

5. Of all the 1,600 resignees, 39 percent resigned because of reasons having nothing to do with the job—marriage, maternity, moving, and demands of the home—reasons beyond agency control, once the employees in question have been recruited and hired. Practically all of these were women.

6. Women on the agencies' staffs at the beginning of the study year outnumbered men by nearly 5 to 1. Women 30 years of age or younger comprised over a fifth of total staff, more than a fourth of all caseworkers. Men of all age groups comprised 15 percent of the casework staff. Most of the men were married; most of the women, single. Of the men, about two-thirds had completed 2 or more years of graduate social work education; of the women, fewer than half. Men had a significantly higher resignation rate (total, 20 percent; caseworkers, 25 percent) than women (total, 17 percent; caseworkers, 20 percent).

7. Of all resignees, 12 percent reported that they did not intend to return to social work, or preferred other fields should they return to employment. About 22 percent were uncertain about returning to employment or to social work. The remaining 66 percent were already reemployed in, or reported definite intention to return to, social work.

8. Of the child-welfare resignees, slightly over a third reported that they were reemployed in, intended to return to, or preferred child-welfare work; of the family-service resignees, slightly over a fourth reported similar interest in family-service work. The remaining resignees expressed interest in fields other than, or uncertainty about, the field from which they had resigned.

There are significant differences when the three study fields (public child welfare, voluntary child welfare, and voluntary family service) are compared; also in findings for fully trained, partially trained, and untrained staff. These will be detailed in the full report, to be published by the Children's Bureau later this year.

—William B. Tollen

Conference on Mental Health

On April 10–11, the Committee on Preventive Psychiatry of the State University of Iowa held a Second Institute on Preventive Psychiatry, assisted by the Grant Foundation, the Iowa Mental Health Authority, and divisions of the Iowa State University, building on work done at the first institute 2 years ago.

The keynote speaker was M. Brewster Smith, professor of psychology, New York University, with the topic "Recent Contributions of Research to the Development of the Concept 'Creative Mental Health.'" He pointed out the strengths and weaknesses of three approaches being used: (1) analyzing the behavior of persons judged to be mentally sound; (2) using many criteria to derive indices of mental health from the study of large samples; (3) following the mainstream of research in personality development to find out how mental health values cluster and compete with other values "in the arena of personal and social choice."

There is little which is yet firm in mental health research, Professor Smith indicated, but a great deal of promise in a combination of these leads. The particular advantage of the third approach, he said, is the "out" it gives in trying to account for persons who by ordinary definitions are mentally healthy but socially destructive or who are extremely creative but mentally ill. "Mental health thus viewed," he concluded, "is complex and not easily schematized. . . . We will not always want to give it priority."

John W. Lovett Doust, M.D., associate professor of psychiatry, University of Toronto, reported research going on at his institution on the relationship between the very early physiological experiences of the fetus and predisposition to psychiatric disorders, particularly schizophrenia. Anoxia during gestation, he said, may result in morphological immaturities which account for

later neurological and psychological deficits.

A study of the interrelationships between the social environment and health and their implications for the prevention of mental illness was reported by Lawrence E. Hinkle, Jr., M.D., of the New York Hospital, Cornell Medical Center. This research, he said, indicates so far that people, regardless of cultural and other environmental differences, fall into two groups on the basis of their general susceptibility to illness—the "well" and the "ill"—which are noticeably different in the way they perceive their lives.

In other papers Harold J. Berman, professor of law, Harvard University, compared Russian and American legal systems, and Ralph D. Rabinovitch, M.D., director of Hawthorn Center, Northville, Mich., reviewed studies on the genetic aspects of mental illness—both finding implications for prevention.

The conference discussions afforded opportunity for participants from many scientific disciplines to explore the interrelationships between two conceptions of mental health: prevention of mental illness and a positive creative human development.

—Muriel W. Brown

Health Studies

Analysis was recently completed of the data gathered in the first stage of the project being carried out jointly by the Children's Bureau and the National Office of Vital Statistics to learn something of the size and characteristics of the health problem presented by cystic fibrosis of the pancreas. (See CHILDREN, January–February 1959, p. 36.)

In the first stage of the study, carried out January 8–February 13, 1959, figures on patients with cystic fibrosis were requested from a sample consisting of 616 hospitals in continental United States—about 9 percent of the nonpsychiatric hospitals listed in hospital directories for 1958. All 296 of the hospitals approved for pediatric residency were included in the sample. The information collected covers each of the 6 years 1952–57, and includes: (1) number of patients with diagnosis of cystic fibrosis discharged from the hospital, including discharges due to death; (2) total number of discharges of such patients; (3) number of deaths of such patients in the hospital. More detailed information was received for the year 1957.

The survey indicates that from 1952 to 1957 the number of persons with a diagnosis of cystic fibrosis discharged from hospitals, including those who died, increased by 50 percent—from estimated totals of about 1,700 to about 2,500. About 98 percent of these patients were under 20 years of age. The estimated number of persons with a diagnosis of cystic fibrosis dying in hospitals increased by about 20 percent between 1952 and 1957—from about 300 to 360. The data also indicate an increase during the period in the total number of discharges, from an estimated 2,100 in 1952 to 3,200 in 1957.

According to the study directors, the increases in hospitalization on account of cystic fibrosis probably resulted in part from improved diagnostic procedures. They also point out that the fact that these increases occurred chiefly in hospitals other than those approved for pediatric residency suggests an increased awareness of the disease outside of the pediatric centers.

The numbers of persons with diagnosis of cystic fibrosis dying in hospitals ranged between 14 and 25 percent of those discharged during the 6 years. From another study, based on information obtained from a sampling of 1958 death certificates, the National Office of Vital Statistics found that in 1958 one-fourth of deaths attributed to cystic fibrosis occurred outside of hospitals.

As the joint project progresses, the survey data will be combined with other information to give an overall estimate of the frequency of cystic fibrosis in the general population.

The full report of the survey will appear in a coming issue of *Public Health Reports*, published by the Public Health Service, Department of Health, Education, and Welfare.

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Seeking a quick and inexpensive method of discovering heart abnormalities early in life, the Public Health Service is cooperating with the following Chicago groups in recording the heart sounds of 40,000 children in Chicago public elementary schools: the local heart association, the city boards of health and education, and the county medical society. Each heart-sound recording is listened to by at least two cardiologists, and the findings of each are checked against the other to obtain greater accuracy.

A followup screening physical examination is then performed by the cardiologists on children whose heart sounds are not normal. Children with examination results defined as positive for heart disease are then referred to a private physician or clinic for diagnosis and treatment.

Through the study, which will last 18 months, the participating agencies expect to find out what operational problems may be involved in mass screening programs for discovering heart defects. Epidemiological data will also be collected on children with previously undetected heart defects, which are located with the help of the heart-sound recorder.

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A pilot study of New York City teenagers who have contracted or been exposed to a venereal disease has been begun by the American Social Hygiene Association. The purpose of the study is to find some of the social factors leading to infection among persons under 20 years of age and to arrive at a means of control through effective case-finding techniques. The study, which will consider the social, economic, and cultural background of each teen-ager included, is being carried on in city venereal-disease clinics with the cooperation of the city health department.

Prenatal Care

Lack of prenatal care of mothers was associated with deaths of babies in the first month of life in a study of 1956 live-birth and death certificates made recently by the District of Columbia's Department of Public Health.

Among infants born alive of mothers who had had no prenatal care the neonatal mortality rate was 48.0 per 1,000 live births, more than twice the rate for all infants born alive in the District, which was 20.8. About one-fourth of all the neonatal deaths during the year occurred among the babies of women who had had no prenatal care. Among the babies who died in the first month of life whose mothers had had no prenatal care more than 80 percent were born prematurely—their birth weights were less than 2,501 grams.

In a study of some 5,800 live births occurring in the same year at the municipal hospital where about half the mothers had received some prenatal care and the rest none, it was again

found that the neonatal mortality rate for babies of mothers who had received no prenatal care was more than twice as high as for the group that had received such care. The mothers in both groups were of similar economic status, since the hospital is used for obstetric care only by persons regarded as "medically indigent." The neonatal mortality rates for both groups were somewhat lower than the rates for the corresponding groups among all live births in the District.

White House Conference

A plan for the program structure of the 1960 White House Conference on Children and Youth was adopted by the executive committee of the President's national committee early in May

About 7,000 persons are expected to attend the Conference, which will open and close with plenary sessions. Every delegate will be assigned with some 30 other persons to one of about 200 work groups, each dealing with a defined subject.

The Conference will have daily "Theme Assemblies" of about 1,400 persons each, in which a number of work groups will gather together for a presentation related to the Conference theme. Work groups having closely related topics will then meet in forums of about 350 people to hear presentations of facts and issues related to the theme and to their specific subjects of concern.

At the final plenary session the delegates will hear reports on various subjects, prepared with the help of elected representatives from each work group, and reflecting both majority and minority opinions. These reports will become part of a published record of the Conference.

Plans for the White House Conference also call for the preparation of pre-Conference materials to include the following:

1. Two volumes synthesizing preparatory reports submitted to the Conference. One will be a compendium of information on State and community activities and concerns relating to children and youth. Data for this volume are now being collected by the various State committees for the White House Conference. The other volume will be an integrated digest of studies and activities reported by members of the Council of National Organizations.

2. Three volumes of "background papers" written by specialists at the invitation of the studies committee: (a) "Perspectives," a collection of historical and philosophical essays relating the Conference stress on values and a changing world to various areas through such topics as "The Older and the Newer Generation," "From Frontier to Suburbia," and "The New World of Science"; (b) "Trends," a group of papers on recent changes in demography, rural and urban life, occupations, women in industry, and other factors influencing family life and young people's futures; (c) "Issues," consisting of papers on open questions affecting children and youth, such as genetic factors in growth and development, problems of minority groups, and the role of government in family life.

3. A Chart Book graphically highlighting factors and trends affecting children and youth today. This will be divided into four main sections: "The Changing World"; "Problems of Children and Youth"; "Current Programs"; and "Projections of Present Trends." The book is being sponsored by the Federal Interdepartmental Committee on Children and Youth, which is providing the data, with the Children's Bureau contributing technical assistance.

4. About 50 "working papers" prepared by persons selected as experts in their subjects, containing resource materials for use in the work groups.

5. The "Conference Workbook," containing the program and questions which may be used as guides for work group discussions.

Family Law

As a first step in the consideration of a plan to set up a research center for the interdisciplinary study of family law at Duke University, the university's law school held a 3-day conference in early April of representatives of various social sciences and professions from both inside and outside the university. Purpose of the conference was to consider the possible usefulness of bringing to bear the points of view and knowledge of such disciplines as sociology, anthropology, economics, psychology, religion, social work, and psychiatry, together with law, in studying the concerns of family law—divorce, separation, adoption, guardianship, custody, support, family courts—in an effort to contribute to the law's objective, the stability of the family.

The 15 conferees included representatives of various schools and departments of the university and 8 persons from outside the university. The latter group was composed of a family court judge, a practicing attorney, two professors of sociology, two professors of law, a theologian, and a representative of the research division of the Children's Bureau. The group saw promise in the proposal and recommended that the possibilities of setting up the center be pursued further.

Juvenile Delinquency

The American Public Welfare Association, in a recently issued statement of policy, urges State public welfare departments to take the lead in planning and providing unified administrative direction to efforts to prevent and treat juvenile delinquency. Pointing out that the prevention and treatment of delinquency require a broad range of facilities and services that affect the well-being of children and youth, the association lists the following among the kinds of services that State welfare departments should "administer, supervise, or directly reinforce through consultation, standard setting, and licensing": social services and financial assistance related to wholesome family living; casework services to assist courts; institutional treatment; aftercare services; consultation to law enforcement agencies; detention; shelter care; fact gathering; and research.

The association recommends that public welfare departments emphasize measures to attract and develop staff "qualified and temperamentally suited to work with adolescents," experiment with new methods and types of services, cooperate with other agencies having common or related objectives, and maintain the identity within their departments of those aspects of delinquency services which are necessarily specialized.

Copies of the policy statement, which is entitled "State Public Welfare Department Responsibility for Leadership in Juvenile Delinquency Services," may be obtained from the Association, 1313 East 60th Street, Chicago 37, at 25 cents each, with discounts for purchases in large quantities.

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Direct observation of inmate systems of correctional institutions by social workers responsible for devising institutional social services was advocated

at a workshop on services to groups in correctional institutions, held in conjunction with the annual program meeting of the Council on Social Work Education last January. The participants were faculty members of schools of social work and superintendents and social work staff members of correctional institutions. The entire focus of the workshop was on the implications of the inmate system.

After defining an inmate system as a group response to the institution's system of control, the participants agreed that inmate systems in various institutions differ from each other, and that the nature of the system within a particular institution can only be learned through observation of informal and work groups together with analysis of the factors within the institution's structure which tend to foster antagonism to its purpose.

Such observation, it was asserted, could not be done from behind a desk, and requires a little different perspective and set of skills than most social workers have developed during social work education and noninstitutional experience. It was suggested, however, that a group worker might be helped to move into the situation by his experience with groups.

It was generally agreed that a social worker coming into an institution must enlist the participation of all institutional staff members in designing his plan for providing social services.

Agricultural Migrants

Representatives from 18 States and 18 national voluntary agencies met in St. Louis, April 7–9, at the Mid-American Conference on Migrant Labor, sponsored by the President's Committee on Migratory Labor and the Council of State Governments. The conference included workshops on the following subjects: children and youth, housing and sanitation, public health and public assistance, employment, and governmental and community responsibilities. Among the many actions they recommended were the following:

Enforcement of school attendance laws for all children, including migrants, and making available to schools simple educational records on migrant children.

Establishment of summer schools for migrant children.

Enactment of legislation setting a minimum age for agricultural employment of children outside school hours.

Development of community centers for recreation, day care of children, and health care.

Establishment by local health authorities and medical societies of health services for migratory families, especially in home base areas.

Development by State health departments of uniform health-history cards for migratory families.

Enforcement of State housing and sanitation codes for labor camps and exploration of the possibilities of central housing for migrants.

Study by localities of the feasibility of constructing new housing for migrants or employing nonmigrants.

Appointment of one migrant within each labor camp as a paid sanitary officer to work with a committee of camp residents.

Assumption of responsibility by health and educational agencies for training migrants in homemaking, child care, and nutrition.

Study of the feasibility of developing insurance programs to cover migrants' risks such as sickness, accidents, and unemployment.

Inclusion of the migrant population in the preparation of public-assistance budgets and plans in "migrant-impacted areas."

Cooperation of Federal and State governments in programs to license crew leaders, develop family records, provide safe transportation, license work camps, and distribute surplus commodities.

It was also recommended that the Mid-American Conference on Migratory Labor be made permanent.

Child Welfare

The Advisory Council on Child Welfare Services, established at the direction of the 85th Congress, held its first meeting May 4 and 5 to begin study of the effect of the 1958 amendments to Title V, part 3 of the Social Security Act and to consider the possibility of making recommendations for change, as charged by the Congress. The meeting was largely devoted to determining the scope of the Council's future deliberations and in devising procedures for carrying out the charge. The Council, which is to report to the Secretary of Health, Education, and Welfare and to the Congress by January 1, 1960, includes representatives of public, voluntary, civic, religious, and professional welfare organizations and groups, as well as of the general public.

John C. Kidneigh, director of the School of Social Work, University of Minnesota, is the Council's chairman. Its other members are: William T. Coleman, Jr., lawyer, Philadelphia; Fred DelliQuadri, director, division for children and youth, Wisconsin Department of Public Welfare; Very Rev. Msgr. Raymond J. Gallagher, chairman, program committee, National Conference of Catholic Charities; Maurice B. Hexter, executive vice president, Federation of Jewish Philanthropies of New York; Margaret Hickey, public affairs editor, *Ladies' Home Journal;* H. Harold Leavey, vice president, California-Western States Life Insurance Co.; Leonard W. Mayo, chairman, division of Christian life and work, Department of Social Welfare, National Council of Churches; Joseph H. Reid, executive director, Child Welfare League of America; William G. Stratton, Governor of Illinois; Thomas J. S. Waxter, director, Maryland Department of Public Welfare; and Ellen B. Winston, commissioner, North Carolina Board of Public Welfare.

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Charged with looking into the increase in illegitimacy in relation to the aid-to-dependent-children program, a committee of South Dakota's Legislative Research Council reported last fall that it had found no causal relationship between the two. Attributing the increase in the number of families receiving aid to dependent children to family breakdown due to changes in the economic and social life, the committee recommended against legislation that would place special restrictions on the amount of payments that mothers of illegitimate children might receive and asked that "additional emphasis be placed upon and additional funds be provided for social welfare work within the Department of Public Welfare."

Accidental Poisoning

Children under 5 were the patients in more than four-fifths of the 15,000 cases of accidental poisoning reported to the National Clearinghouse for Poison Control Centers, Public Health Service, during the 3½ years ended December 31, 1958. Practically all the rest of the

cases involved persons under 15. Eighteen of the accidental poisonings in children under 15 resulted in death. The poisonings were reported by 59 local poison-control centers, located in 21 States and the District of Columbia.

Aspirin was the top cause of poisoning, accounting for one-fourth of the cases reported. Most of the persons poisoned by aspirin were small children, who swallowed candied aspirin. Children also were reported as swallowing bleaches, detergents, soaps, water softeners, polishes, lighter fluid, cosmetics, insecticides, weed killers, and various kinds of medicines.

The circumstances which most frequently led to the swallowing were: (1) The products were kept in old bottles or food cans instead of their original containers; (2) they were elsewhere than in their usual storage place; (3) the storage place was not locked and was in reach of the child.

The National Clearinghouse for Poison Centers has been receiving reports from local poison-control centers since its establishment in 1957. Most such centers are located in hospitals and maintain 24-hour telephone service, providing private physicians with information about the ingredients of trade-name products and about antidotes and other treatment. If a nonmedical person calls a center, he is given first-aid instruction and advised to call his physician. The first center was established in 1953 in Chicago. (See "A New Life-Saving Service Is Launched," by Edward Press, CHILDREN, May–June 1954.)

Today there are a total of 262 poison-control centers located in 42 States. The principal supporters of the local centers are State chapters of the American Academy of Pediatrics, State and city health departments, medical schools, and local medical societies. Some are financed by parent-teacher associations and men's and women's service clubs.

The National Clearinghouse for Poison Control Centers serves local centers by providing them with information on new products obtained either from manufacturers or from other local centers. When requested, more than 200 major producers of drugs and household products voluntarily inform the Clearinghouse about the ingredients of their products and the antidotes for any poisons in them. The Clearinghouse also assists communities that wish to establish poison-control centers.

Miscellaneous

Reported births of children to American parents abroad amounted to 46,070 in the fiscal year ended June 30, 1958—about one percent of all births recorded in the United States for that period. The number exceeds the birth registrations for the period in 19 of the States.

Reports of children born to Americans outside the country are filed voluntarily with the nearest United States consular officer. He forwards these reports to the U. S. Department of State, which accepts them for permanent filing if the child is an American citizen according to this country's nationality laws. Determination of citizenship is based on such facts as the parents' identification, the precise intervals they resided in the United States and elsewhere, and similar items. Thus, this document will serve the child throughout his life not only to establish the facts of birth but also citizenship.

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To help prevent childhood accidents the American Academy of Pediatrics has issued a set of six 1-page leaflets for distribution to mothers through physicians. The leaflets offer tips to mothers for keeping babies and little children safe. Copies may be had from local diaper services and from the American Academy of Pediatrics, P. O. Box 116, Evanston, Ill.

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The Ford Foundation recently announced a grant of $195,000 to the University of Michigan for a national study of family income, with special emphasis on low-income groups and the causes of poverty, and a grant of $24,850 to support a year-long analysis of research and experimental programs in youth development. Preliminary research in the youth study will be concerned with such subjects as creative leadership and responsible maturity, passive conformity, and rebellious delinquency and will be planned as the basis for long-term studies.

Correction

The homemaker pictured on page 111 of the May–June issue of CHILDREN is with the Family and Children's Service in Minneapolis, where she has been for the past 10 years, and not with the Catholic Charities of Cincinnati.

Guides and Reports

FINDING MORE FOSTER HOMES; a special recruitment campaign, sponsored by the Council of Social Agencies of Rochester and Monroe County, N.Y. 1959. 39 pp. $1.50.

Explains in detail the methods used in a concentrated one-month effort to find foster homes, carried on together by the five child-placing agencies in a county.

COUNSELING PARENTS OF CHILDREN WITH MENTAL HANDICAPS; proceedings of 1958 Woods Schools Conference, held in Minneapolis in cooperation with the University of Minnesota. Woods Schools for Exceptional Children, Langhorne, Pa. 1958. 108 pp.

Includes in the discussions a statement of principles for counseling as soon as retardation is discovered.

CHAPEL HILL WORKSHOPS, 1958. Part 1, Workshops for Houseparents of Children's Institutions. 54 pp. 75 cents. Part 2, Workshops for Executives of Children's Institutions. 36 pp. 75 cents. School of Social Work, University of North Carolina, Chapel Hill. 1958.

Presents reports summarizing the findings of workshops for personnel of children's institutions, held under the auspices of the Child Welfare League of America and the University of North Carolina School of Social Work, July 1958.

REPORT OF NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON MENTAL RETARDATION, 1958. Legislative Document No. 83 (1958). The Committee, Albany, N.Y. 1958. 79 pp. Available on request from the Committee.

Describes New York State's legislative accomplishments for the mentally retarded, the Joint Legislative Committee's proposals for the future, and the progress made by the State departments of education and mental hygiene, the Interdepartmental Health Resources Board, and private groups.

IN THE JOURNALS

Radioactivity Study

High natural radioactivity of the environment was correlated statistically with high rates of congenital malformations in a study of birth and death certificates of more than a million children born 1948–55. The study is reported by John T. Gentry, Elizabeth Parkhurst, and George V. Bulin, Jr., in the *American Journal of Public Health* for April 1959. ("An Epidemiological Study of Congenital Malformations in New York State.")

The New York State Department of Health, which made the study, examined the birth certificates of all the children born in those years in all parts of the State except New York City, and the death certificates of all those who died before reaching their fifth birthday. The certificates indicated that the average malformation rate for all the 946 townships included was 13.2 cases per 1,000 live births, and that in 186 townships it was 20.0 or more.

After a compilation was made of the geological data on the natural radioactive deposits, it was found that the areas in New York State with the greatest amounts of natural radioactive materials are those with outcrops of igneous rocks. These areas had the highest malformation rate, 17.5 cases per 1,000 live births.

Reporting the study, the department notes that the statistical associations found represent only a first step in establishing a possible cause-effect relationship between natural radioactivity and congenital malformations.

Child Care in the USSR

In the Soviet Union great emphasis is put on the care of children, says Leona Baumgartner, M.D., in the *American Journal of Public Health* for May 1959. ("What About Soviet Medicine and Public Health?") The Government operates many nurseries for children from shortly after their birth to 3 years of age, the author notes, adding however that there are not enough nurseries to keep up with the demand. The children may stay at the nursery while the mother is at work, or all the time; mothers are given time off to go to the nursery and breast-feed their babies. A pediatrician is in charge of each nursery and supervises the children's diet, inoculations, rest, and play, and when a child is sick the pediatrician cares for him either in the nursery or at home.

The author notes that in the nurseries she visited there was a high ratio of staff to babies and little turnover in staff—so that the babies got continuing attention from the same person. The children in the nurseries seemed to her to be less spontaneous in their behavior than American children of the same age, but they looked so healthy and happy that she questions whether the evidence against caring for babies and small children in day nurseries should not be reexamined.

Maternity leave with full pay is given to mothers—56 days before and 56 days after the baby's birth, and more if medically needed, according to the author. Most mothers are delivered by midwives under the supervision of physicians. All maternity care is provided by the Government, and the mother of a child born out of wedlock receives the same medical care as any other mother. The author was told that when an unmarried mother names the putative father of her child 25 percent of his pay is automatically withheld for the child's support.

Maturing of Social Work

Mothered by sociology, with psychiatry as a father figure, social casework has passed through a number of developmental stages before reaching its present mature status, says Helen Harris Perlman, professor of social work at the University of Chicago, in *Public Welfare* for April 1959. ("Social Casework Today.") While its early devotion to sociology had resulted in too exclusive an emphasis on the external environmental aspects of the client's life, its sudden shift to an infatuation with psychiatry resulted in an equally exclusive emphasis on the client's "internal environment," says the author. Maturity came, as with all adolescents, she continues, when social casework began to recognize its own sense of identity as separate from that of either of its parents.

With this maturity has come the ability to acknowledge its antecedents; to balance and fuse its "grasp of psychodynamics with its emerging understanding of sociodynamics." Social casework is now increasingly focusing its attention on individuals having trouble in carrying out one or more of their social tasks—being a parent, a spouse, a student, a worker. This focus, she says, of necessity takes cognizance of the client's social environment, which includes the "living network of those people with whom he is in vital interaction." Finally, she adds, it is a mark of maturity that social casework no longer is giving its attention only to persons who want help and are regarded as "treatable," but increasingly considers the possibility of helping people to want help, stimulating them to want to change their standards and behavior.

Family Court Act

In devoting its April issue to family courts the *NPPA Journal* includes the text of the proposed Standard Family Court Act, drafted by a committee of the National Probation and Parole Association in cooperation with the Children's Bureau and the National Council of Juvenile Court Judges. The family court, as proposed, would include juvenile-court jurisdiction as well as jurisdiction over all domestic relations issues. The act also sets up detailed procedures to protect children in detention and during hearings.

Comments on each section give the reasons for the phraseology used and explain differences of opinion among committee members.

Juvenile Court Dilemmas

The essential function of a juvenile court is "to hold the balance true between the interests of the individual and the interests of society," says Eileen L. Younghusband in the *Social Service Review* for March 1959. ("The Dilemma of the Juvenile Court.") This, she says, results in a number of dilemmas, including the necessity to concentrate on the offender rather than the offense without condemning or condoning and at the same time to repre-

sent a limit-setting authority. Among the difficulties she finds the courts facing in these efforts are not only insufficiently developed diagnostic and treatment services, but also a gap between the attitudes and purposes of an enlightened juvenile court and the functions of courts in the minds of young offenders and their parents.

The essential dilemma of a juvenile-court system might be summarized by saying that juvenile courts have too much power and too little knowledge, the author concludes.

Some safeguards she suggests for delimiting the power are: clearly defining the acts designated as offenses; ordering the life of the community to make it easy to keep the law and hard not to get caught breaking it; providing good preventive services; protecting persons from wrongful arrest and destructive experiences after arrest; providing the courts with the necessary range of supportive diagnostic and treatment services.

In addition to increased knowledge about the causation of juvenile delinquency, courts need a social philosophy in which the young delinquent is respected and dealt with as an individual human being, the author maintains.

READERS' EXCHANGE

CHWAST: ***The "social unconscious"***

In illuminating the crucial problem of conflicting social values in the treatment of delinquents, Lt. Chwast joins the growing group of practitioners and investigators who are calling attention to the social structural dimension of a process which has been traditionally conceived in one-to-one terms. ["Value Conflicts in Treating Delinquents," by Jacob Chwast, CHILDREN, May–June 1959.] It is becoming increasingly apparent that the treatment approaches which are successful with upper-middle-class neurotics are not automatically adaptable to working-class delinquents. While many clinicians have become aware of this fact, psychodynamic reasons have been characteristically invoked to explain psychotherapeutic difficulties with the latter group.

Lieutenant Chwast rightly emphasizes the fact that social-value conflicts may have to be dealt with when the middle-class therapist attempts to treat the lower-class client. He refers to a phenomenon which I have tended to call the "social unconscious." This is a psychoanalytically flavored way of describing the social structural forces which impinge so powerfully, yet so covertly, upon all the vital conditions of living that come under review in the treatment process—philosophical views, interpersonal relationships, and familial and occupational attitudes and goals. Perhaps, having been made aware of the power of the individual unconscious through psychoanalytic discoveries, we must now come to understand the way in which our "social unconscious" weaves itself into every aspect of our lives.

Research in social psychiatry, such as that conducted by the Yale group under Hollingshead and Redlich, has pointed to the strong concentration of psychoanalytic and interpretive psychotherapeutic activity among patients in the upper half of the socio-economic scale. The investigators appear to advocate the development of more "5-dollar therapists" as an answer to this problem. Such a conclusion may be erroneous.

The difference in social values at different ends of the socio-economic scale may actually testify against the advisability of uncritically applying the standard psychoanalytic treatment model to therapeutic problems in the lower-class groups. Rather, it may be necessary to develop entirely new treatment approaches for those whose social values do not reverberate sympathetically with middle-class ideals of maturity, introspection, and deferral of gratification. The traditional techniques might be replaced, not necessarily by a frenetic overactivity on the therapist's part, such as Lt. Chwast seems to suggest, but by the development of entirely new nonverbal treatment techniques.

Certainly understanding of the social structural dimension of the treatment process may yet help to provide a means of breaking through these technical barriers.

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JOSSELYN: ***A clinician's viewpoint***

Pediatricians who are involved in developing adolescent clinics are most grateful to Dr. Josselyn for indicating a specific supportive role which can be played by understanding physicians, social workers, youth leaders, and teachers in rendering a broad degree of service to the adolescent. [See "Psychological Changes in Adolescence," by Irene M. Josselyn, CHILDREN, March–April 1959.] Such workers should also read her book, "The Adolescent and His World" (Family Service Association of America), for more complete exposition of her concepts.

There is no part of her article which is more helpful than that relating to the anxiety of professional people in dealing with adolescent clients. An enlightened, sympathetic, but at the same time highly skilled point of view is badly needed in this field of medicine. With less anxiety about the management of the problems of adolescence comes increasing understanding that the growing person derives much strength from the security of limitations and discipline and the fact that some struggle in developing maturity and independence is physiological and probably indispensable.

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